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ABSTRACT

The changing educational needs of midwives in England were assessed, and an open learning package for midwives was developed based on the findings. Data were collected from the following: questionnaires mailed to 1,100 registered midwives (70% response rate), all 205 coordinating supervisors of midwives in England (83% response rate); 1 randomly selected consultant obstetrician from each of England's 205 maternity units (58% response rate); one obstetric registrar from each of England's 196 maternity units employing obstetric registrars (46% response rate); national random sample of 250 general practitioners (65% response rate); case studies of 2 midwifery units across England and focus group interviews with midwives and managers at the units; interviews with a geographically and socially representative sample of 115 mothers served by midwifery clinics, and interviews with representatives of six national organizations involved in developing the nation's maternity service. The study findings were synthesized into an open learning package containing four units on relationships in practice and four on the context of midwifery care. Appended is an overview of the open learning package unit contents and a list of individuals involved in developing the open learning package. (The report includes 106 tables/figures and 215 references). (MN)

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IDENTIFICATION OF THE CHANGING EDUCATIONAL NEEDS OF MIDWIVES IN DEVELOPING NEW DIMENSIONS OF CARE IN A VARIETY OF SETTINGS AND THE DEVELOPMENT OF AN EDUCATIONAL PACKAGE TO MEET THESE NEEDS

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Rosemary Pope
Margaret Cooney
Lesley Graham
Mary Holliday

The University of Greenwich

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Research commissioned by the English National Board for Nursing, Midwifery and Health Visiting, London

English National Board for Nursing, Midwifery and Health Visiting
Victory House
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IDENTIFICATION OF THE CHANGING EDUCATIONAL NEEDS OF MIDWIVES IN DEVELOPING NEW DIMENSIONS OF CARE IN A VARIETY OF SETTINGS AND THE DEVELOPMENT OF AN EDUCATIONAL PACKAGE TO MEET THESE NEEDS

PREFACE

The Board is pleased to publish the report which provides an exploration of the current role of midwives and identifies changing educational needs within the scope of the Midwife's Code of Practice. An educational package to provide a framework for study, based on individual woman centred care was developed on the basis of these findings. Both the report and the educational package make an important contribution to the quality of woman centred care during child birth.

Through a variety of means the Board ensures that education for practice continues to be relevant both professionally and academically. Research based evidence provides a further important dimension for the development of policy. The findings from all the research commissioned by the Board will be considered with a view to confirming or developing the Boards educational policies.

M. Theobald

Maureen Theobald
Chairman of the Board

Jeff Thompson

Professor Jeff Thompson
Chairman of the Research and Development Group

Identification of the Changing Educational Needs of Midwives in Developing New Dimensions of Care in a Variety of Settings and the Development of an Educational Package to meet these needs

PROJECT TEAM

Rosemary Pope
Margaret Cooney
Lesley Graham
Mary Holliday

UNIVERSITY OF GREENWICH, SCHOOL OF HEALTH

Any enquiry regarding the project should be addressed to:

Dr Rosemary Pope
Elizabeth Raybould Centre
Stone House Hospital
Bow Arrow Lane
Dartford Kent DA2 6PJ

ACKNOWLEDGEMENTS

STEERING GROUP

Lesley Page	Professor of Midwifery and Women's Health, Centre for Midwifery Practice, Queen Charlotte's Hospital (Chair)
Louise Silverton	Director of Education and Practice Development, Royal College of Midwives (Chair - Second Year)
Linda Brown	Course Director, Midwifery, Distance Learning Centre, University of the South Bank
Roslyn Corney	Professor of Psychology, School of Social Sciences, University of Greenwich
Sonia Crow	Assistant Director of Educational Policy, Research and Development, English National Board for Nursing, Midwifery and Health Visiting
Maggie Redshaw	Research Fellow, Institute of Child Health, University of Bristol
Cynthia Rickitt	Head of Midwifery Services (retired), Sunderland District Hospital
Meryl Thomas	Director - Midwifery Education and Practice, English National Board for Nursing, Midwifery and Health Visiting
Jane Wardropper	Education Officer (retired), English National Board for Nursing, Midwifery and Health Visiting

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EXECUTIVE SUMMARY

1. BACKGROUND

Radical changes have occurred within the health service over the recent years e.g. Community Care Act, purchaser/provider split, Health of the Nation, management by local Trusts, and fundholding by General Practitioners. It is likely that the effects of such changes will continue to impact on the provision and delivery of all health care services. The maternity services are an important focus for change and various reports have recently been completed which aid an understanding of the prevailing situation and increase the impetus for change(5,6).

Much of the recent work on the maternity services emphasises the importance of the role and responsibilities of the midwife in delivering a responsive, high quality effective and efficient service. It is apparent from the available evidence that despite the obvious potential and efforts of midwives to provide an optimum service, significant gaps in provision exist(3,4,6).

In this context, the ENB commissioned the University of Greenwich to undertake a study with the following 3 aims:

(1) to establish the current role and responsibilities of midwives in a variety of settings with a range of client groups **(6 months)**.

(2) to identify the changing educational needs of midwives to fulfil their future widened role and responsibilities within changing maternity services **(6 months).**

(3) to develop an educational package to facilitate midwives in responding to the requirements of their changing role and responsibilities **(one year).**

2. METHODS

The research aspect of the study was undertaken for the primary purpose of identifying the continuing educational needs of midwives in order to develop an educational package to meet such need. It was therefore necessary to obtain information on the wide spectrum of activities related to midwifery practice as defined in The Midwife's Code of Practice(9).

In the light of the broad remit of midwives, and the emphasis placed on the provision of woman-centred care, it was considered appropriate to adopt a framework for study that would allow the potential breadth of the midwives role to be investigated within this context. Therefore, the concept of individualised care was chosen to underpin the framework for data collection. Individualised care is based on the assumption that high quality care depends on the recognition of individuals as having unique needs. The importance of addressing social and emotional, as well as biological and physiological needs is stressed. The aim is to provide a supportive relationship within which care is provided.

2.1 Aim 1: To establish the current role and responsibilities of midwives working in a variety of settings with a range of client groups (6 months)

Postal questionnaires were sent to the following groups:

(1) A national stratified random sample of NHS midwives (n=1100). Response rate: 70%.

(2) All co-ordinating supervisors of midwives in England (N=205). Response rate: 83%.

(3) One consultant obstetrician selected at random from each maternity unit in England (n=205). Response rate: 58%.

(4) One obstetric registrar from each maternity unit that employed obstetric registrars in England (n =196). Response rate: 46%.

(5) A national random sample of general practitioners (n=250). Response rate: 65%.

The content of the questionnaires covered a wide range of issues including:

maternity service provision, the role and responsibilities of midwives, perceived competency/confidence of midwives to undertake their full role, the continuing education and training needs of midwives, and the most appropriate means for meeting outstanding need (supervisor and midwife versions only).

2.2 Aim 2: To identify the changing educational needs of midwives to fulfil their future widened role and responsibilities within changing maternity services (6 months)

In order to follow-up key issues raised in the questionnaires, and to obtain detailed information concerning the development of the educational package case studies were undertaken in 3 sites across England. A semi-structured topic guide was used to interview a total of 90 midwives, and a small number of midwife supervisors, managers, educators and doctors.

In addition, a fairly small sample of mothers from 2 of the case study sites were interviewed (n =115), in order to illuminate the findings obtained from the professionals, to inform package development.

Finally, interviews were undertaken with representatives from 6 national professional and statutory organisations involved in the development of educational policy for maternity service provision.

2.3 Aim 3: To develop an educational package to facilitate midwives in responding to the requirements of their changing role and responsibilities (one year)

A Curriculum Advisory Group was set up to inform the strategic direction of the package on the basis of the research findings, and a Curriculum Development Group worked specifically on the development of the curriculum.

The quality monitoring process involved the assessment of the package by 20 midwife testers and 13 expert critical readers approved by the ENB.

3. MAIN FINDINGS AND CONCLUSIONS

3.1 Background of practising NHS midwives

- Midwives, supervisors and doctors reported that midwives provided a wide range of aspects of care in line with the activities of a midwife as outlined in The Midwife's Code of Practice(9).

- Over three quarters of midwives reported that they worked within a system of rotation, with just under a quarter working in both hospital and community settings - 'integrated midwives'. A very wide range of systems operated in this respect. Midwives reported that the way the system was organised had a major impact on their confidence and competence to practise.

- Several effects of practice base (community, hospital, 'integrated'), grade, and full or part-time working were reported in relation to the aspects of care midwives provided.

- 'Integrated' midwives reported that they provided care within the widest framework, and both community and 'integrated' staff reported providing care within a wider framework than hospital staff. However, community staff were least likely to report involvement in providing 'enhanced role' aspects of care. It is important to note that it was not possible to determine the *actual extent* of midwives involvement in providing various aspects of care.

- There were also some significant grade effects within practice settings, with those on higher grades generally being involved in a wider range of activities.

- Part-time midwives were more likely than those working full-time to comment on the lack of financial support and time available for them to undertake further study.

- Whilst acknowledging the potential significance of the findings reported above, it is important to recognise that there was considerable individual variation apparent in relation to midwives confidence to practise and their consequent educational needs.

3.2 Provision of woman-centred care

3.2.1 Organisation of care

- A wide range of ways of organising midwifery care were apparent countrywide. A variety of 'systems' and care concepts operated concurrently. For example, the named midwife was frequently reported to operate within a system of caseload management or team midwifery.

- Many midwives and supervisors indicated their strong commitment to providing the best possible service, in the face of enormous structural and organisational change, in often very difficult resourcing circumstances.

- Many examples were provided of ways in which midwives facilitated woman-centred care in a caring and sensitive manner.

However, often this did not appear to occur within a formal quality monitoring framework, and there was a strong indication that the extent to which women's needs were being addressed was subject to a considerable degree of variation.

- The implementation of effective quality assurance mechanisms and the underpinning of care with more structured frameworks at local level may enhance the potential for meeting the needs of all service users.

- The move towards more widespread use of knowledge-led practice within the maternity service appears to be of considerable importance in assuring quality, and increasing the impetus for such developments will remain a priority. Using such knowledge to work effectively within organisational structures to negotiate optimum care for women will be an important aspect of midwifery practice.

3.2.2 Changing Childbirth

- Considerable efforts were being made to implement the Changing Childbirth indicators of success countrywide. Again, it appeared that variation was occurring concerning the extent to which the principles underpinning the report were being observed in relation to implementation.

- Approximately three quarters of the midwives and supervisors and a third of the GP's, consultants and registrars considered that the implementation of Changing Childbirth would improve the quality of maternity services.

3.3 Role and responsibilities of midwives

- Midwives generally seemed very committed to their job and often found a great deal of satisfaction in midwifery. However, they were frequently concerned about grading and remuneration issues, and were anxious in relation to meeting on-call rotas and managing commitments outside work. Concerns were also raised regarding possible disciplinary or litigation proceedings if the care provided was subsequently questioned by managers, supervisors or service-users.

- It will be important to maximise the potential for the provision of optimum care, whilst minimising the potential for undue stress and anxiety being placed on midwives in relation to providing the care required by service-users.

- The role of the midwife in providing care to women experiencing normal pregnancy and childbirth was not very clear in many respects. There was some evidence of doctors being prone to confuse the role and responsibilities of midwives in normal and high risk cases, suggesting midwives should take full responsibility for medical and obstetric emergencies if they wanted to be practitioners in their own right.

- Supervisors were most likely to consider there were areas of unnecessary overlap between midwives and doctors. General practitioners were least likely to consider this to be the case. The main area of unnecessary overlap identified by supervisors and midwives related to the involvement of doctors with low risk women, particularly in hospital on the delivery suite and in the antenatal period.

- Good communication networks between medical staff and midwives at all levels relating to maternity service provision will be vital in facilitating an optimum understanding of roles, and the delivery of an integrated service to local populations.

- Midwives generally had a good understanding of their remit but there were obvious barriers to them undertaking their full role. Again, the extent to which this occurred varied widely, as did perceptions of the midwife as an autonomous practitioner. Some midwives considered that this could only really occur if they made all decisions alone, whereas others negotiated their own practise and hence their autonomy in whatever situation they were working.

- An important issue that emerged related to the extent to which all midwives can provide 'holistic' care, and if and when, specialist midwifery skills will be required. Examples raised in this respect included caring for bereaved mothers and those whose babies had HIV/AIDS or a disability. Further work needs to be undertaken in this respect.

- Another potentially confusing situation arose in relation to midwives remit to provide care for women experiencing normal pregnancies and childbirth, and the extent to which they should be involved in providing more 'medical/obstetric' aspects of care. This is of particular significance as pressure may be put on midwives to assist in the process of reducing junior doctors hours.

3.4 Continuing educational needs of midwives

- Continuing educational needs were identified by midwives and supervisors in several areas. These included research, a range of clinical skills, communication, and counselling related issues. 'General professional issues' such as, the management of change, ethico-legal issues and professionalism was the other main category identified.

- The priority areas identified by midwives for further clinical expertise included: IV cannulation, perineal suturing, ultrasonography, labour and delivery in water and CTG interpretation.

- The issues related to research tended to focus very much around the complexities related to using knowledge derived from various sources - including different research methodologies - to plan, implement and evaluate optimum quality care. In particular, the need for a balance between clinical and technological skills and other types of knowledge was raised as an important issue.

3.5 Midwifery supervision

- The importance of the role of the midwife supervisor in relation to monitoring standards of care, and in providing a support network for midwives was identified. Further information needs to be obtained regarding the most appropriate way of ensuring that the dual aspects of the role are effectively carried out.

3.6 Potential areas for further research

- Several issues emerged in relation to the need for further research.
- Key examples included:

The effects of the organisation of care on a multiplicity of factors including: care outcomes, relative costs and benefits of different types of care provision, and the impact on the personal and professional lives of the workforce.

In particular, further work related to the processes and outcomes of midwife-led and midwife-only care emerged as a priority.

3.7 The educational package

- The educational package that has been developed on the basis of the research findings has been designed to contribute towards addressing many of the needs that have been identified throughout the study.
- The importance of the needs of individual midwives being identified and addressed has been a key tenet of the development of the package. The curriculum has been designed to enhance the move towards the provision of a more integrated, woman-centred service.
- The development of relationships for effective practice, and the context in which care is delivered are the key themes covered by the package. The importance of midwives' capacity to negotiate their own practice from a sound knowledge base in the best interests of those using the service underpins the activities that have been developed throughout the package.
- It will be important that mechanisms are in place at local level to ensure that the needs of those using the package are being addressed, and recommendations have been outlined in the Learning Handbook to facilitate this process. In particular, emphasis has been placed on how the package might be used to facilitate individual programmes of study in line with PREP. Information has also been provided in relation to the procedures that need to be followed if midwives wish to pursue the possibility of using the package to gain academic credit.

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3.8 Continuing education and training need in specific areas

- It was not possible for all the continuing education and training needs of the profession to be addressed through the package that has been developed. In particular, the need for clinical skills and those relating to specialist counselling functions needs to be carefully addressed. Programmes of education and training will need to address locally identified need, and in the light of the dynamic nature of maternity service provision and the broad range of backgrounds of practising midwives regular assessment of outstanding educational need will be a continuing priority.

- In addition, a sample of independent midwives was included in the study. The findings have been outlined in the full report.

CHAPTER 1: INTRODUCTION

This Chapter provides an overview of the context for the study, drawing on legislative and policy initiatives, and relevant perspectives from the available literature relating to the provision of the midwifery service in the United Kingdom, with specific reference to England in the light of the remit of this study.

1. PROVISION OF THE MIDWIFERY SERVICE

Radical changes have occurred within the health service in recent years e.g. Community Care Act(1). Purchaser/provider split, Health of the Nation(2), management by local trusts, and fundholding by General Practitioners. It is likely that the effects of such changes will continue to impact on the provision and delivery of all health care services. The maternity services are an important focus for change and various reports have recently been completed which aid an understanding of the prevailing situation and increase the impetus for change(5,6)

Much of the recent work on the maternity services emphasises the importance of the role and responsibilities of the midwife in delivering a responsive, high quality effective and efficient service.

It is apparent from the available evidence that despite the obvious potential and efforts of midwives[1] to provide an optimum service, significant gaps in provision exist(3 4.)

A complex range of inter-related factors will affect the delivery of the midwifery service which need to be understood if the reasons for identified gaps in service provision are to be addressed. Relevant factors will include: historical legacies, legislation, available resources, national and local policies/strategies, codes of professional conduct and practice, education; individual characteristics, and the attitudes and behaviours of a range of others, including, professionals, managers and consumers(4-8).

2. HISTORICAL AND LEGISLATIVE ISSUES

An examination of historical perspectives regarding childbirth indicate that women have always been cared for by midwives, although issues related to its control have been the subject of heated debate over the years(8). By virtue of the Midwives Act(1902), midwifery attained legal recognition as a profession in England. Over the years, national and international legislation and directives have supported an increasing role for midwives. The full definition of a midwife, and the activities of a midwife in the United Kingdom are outlined in the Midwives Code of Practice(1994)(9). The Midwives' Directive(80/155/EEC) has been incorporated into the Code of Practice. Midwives are entitled to practise independently, and are clinically accountable for their own practice.

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[1] *Female terminology has been used throughout this report in relation to all members of the profession.*

The process by which midwifery attained its current status in the United Kingdom will inevitably have had a major impact on the way in which midwives and others view the role of the profession. Current values, attitudes and practices will have many roots, historical legacy will obviously be one important determinant.

The literature indicates that there has been a struggle for the control of midwifery practice since the seventeenth century, which resulted in a polarisation of views and practices by the mid-nineteenth century; female midwives giving assistance to women in labour and male obstetricians, 'the medical men' intervening in the process of labour with instruments.

There were changes in medicine as well as midwifery in the latter part of the nineteenth century as, after an uneasy truce due to the Medical Registration Act 1858, doctors were defining their intra-occupation fields of control as well as using demarcationary strategies to protect their territory. Following the Midwives Act of 1902, doctors continued to fulfil an important function on the Board which regulated midwifery, and decided the content of the educational programmes.

Over the years since the original Midwives Act of 1902, whilst legislation and directives have supported an increasingly independent role for midwives(9), the professional strivings of midwifery have matched the lay women's voices in a call for the 'humanising' of childbirth - which has come more under medical control.

3. PROFESSIONALISM AND INTER-PROFESSIONAL RELATIONSHIPS

In addition to the issues discussed above a range of factors affecting inter-professional communication within the maternity service have been extensively documented, ranging from broad societal and structural issues, through to individual interactions and characteristics(19-23).

A key concept in this context is that of professionalism, which can be seen to be historically and socially constructed and therefore subject to the dimensions of power, gender and racism. The concept of professionalism was heavily determined by the dominant occupational groups during the latter half of the nineteenth century. Successful projects were then taken to be the paradigm of 'profession' and have been incorporated into many definitions of professionalism.

Hugman(1991) sees power and the use of hierarchies as being the typical underlying structures for most occupations, both intra- and inter-professional groups, and in relationships with the service users. He explores the dichotomy between the traditional/old version of professionalism and the caring professions(68).

A further dimension relates to the trait approach to defining professionalism which has been comprehensively discussed by Hugman(1991). This was used as a measuring tool by which occupational groups could gauge their professionalisation(68). All of the trait approaches signify the importance of learning and intellectual endeavour, variously described as a knowledge base or discrete area of knowledge and a systematic body of theory. Jolley(1989) identifies one of the main criticisms of the trait approach as the uncritical acceptance into theory of the characteristics as portrayed by the established professional groups(72).

Another major implication of the trait approach is that it has spawned the notion of *'semi-professional'*(73 68). The nature of the so-called 'semi-professionals' is further problematised as they are identified as those occupational groups within which the majority of the workforce is female; midwifery being a classical example.

The concept of professionalism has importance for midwifery partly because of its emphasis on autonomy. This is due to the changing power dynamics within maternity service provision. Since the 1950s, there have been changes in the maternity services which have been characterised by the wholesale shift of the place of birth from the home to the hospital; (98% of women give birth in hospital(6)) and the consequent increased input of the medical profession into childbirth.

Midwifery is attempting to redefine and reassert its unique role, leading to claims for greater status. There is a strong move to keep midwifery professionally distinct from the nursing profession, particularly following developments after the Nurses, Midwives and Health Visitors Act 1979(206), when the Central Midwives Board was dissolved, and its functions taken over by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) and the national boards. Alongside this change, by dint of the Griffiths Report(1983), midwifery lost a substantial amount of the managerial authority that had been established through the Salmon Report and the NHS Act 1974(129,131). Separate management structures were often lost, leaving midwives feeling they lacked control over the care they provided, and their professional destiny. During the course of the struggle to regain their professional entity, there have been recent calls for a separate Midwives Act, although not all voices are agreed that this would be the best option for the profession. Another dimension is also developing, a more holistic model which places the woman at the centre of her maternity care. This can be seen as using a strategy discussed by Murphy, which *'aims to change the structure of the positions itself, rather than simply seek inclusion in that structure'*(cited in 68:49).

A 'humanised' version of professionalism has been proposed for midwifery practice - a democratic professionalism which has the concept of partnership and woman-centredness as its foundations. *'An alternative view of autonomy would be to define it as the possibility for caring professionals and service users to act together in formulating the ends and means of service provision'*(68:217).

Individual characteristics and behaviour will inevitably interact with the broader social context in which midwives are working. Past and present experiences will be interpreted by the individual in order to provide a framework for predicting likely future outcomes in the workplace(24-26,161). This process will serve a crucial function in relation to promoting the feeling of control (or otherwise), by the individual over her environment. This process is, of course, dynamic allowing for constant change and re-evaluation. The extent to which changes will be made will be individually determined, but in relation to the professional situation, empowerment can be seen to play an important role. Osterman and Kottkamp(1993) define empowerment as *'......a willingness and drive to act professionally and responsibly, grounded in a sense of self-esteem, competence and autonomy.....'*(209:186). In addition to legislative, structural, social and organisational issues, management and educational strategies will impact on the empowerment of midwives over time (and consequently the potential for integrating new dimensions of autonomy into practice).

4. ORGANISATION AND SYSTEMS OF CARE

Many factors will affect the way care is organised, including national policies, available resources and the deployment of resources; the needs of the local population, and local policies, strategies and procedures.

In addition to the above discussions, many reports and policy documents have influenced the scope of practice for midwives over recent decades. For example, the report by the Peel Committee(1970) recommended that arrangements be made for all births to take place in hospital(10). The Cumberledge Report(1986) advocated neighbourhood-based care(11), and Working For Patients(1989), supported the use of cost-effective care fully utilising midwifery expertise(12). More recently, the House of Commons Select Committee(1992) concluded that women should be given unbiased information and an opportunity for choice in the type of maternity care they receive. This choice included the option of having babies at home, or in small maternity units(6).

Midwives, their managers and educators, have had to take account of many different, and sometimes apparently conflicting, directives, particularly throughout the last two decades, which has affected the type of education that has been organised, as well as the type of service provided.

Most recently, and perhaps most radically, in terms of the scope of practice of midwives, the Changing Childbirth Report(5), proposes a programme of change that is intended to provide a clear way forward for the development of the maternity services into the next century. The recommendations of the report were accepted by the government, and in January 1995 instructions were issued to implement the proposed changes at local level. The Patient's Charter and Maternity Services was also issued to support the change(83).

4.1 Background to Changing Childbirth

The Group responsible for the Changing Childbirth Report was set up as part of the government's response to the Select Committee's Second Report On The Maternity Services(6). The remit of the Group was to review policy on NHS maternity care, particularly during childbirth, and to make recommendations.

Much of the evidence received by the Group supported the need to ensure that care was designed around the needs of the individual woman. The Group put strong emphasis on the importance of ensuring that the woman is cared for by professionals who are acceptable to her, and who have the appropriate skills and expertise required in her particular circumstances. The importance of the woman not having to choose from one profession to the exclusion of the others was noted.

The report went on to propose that each woman should be given the name of an individual midwife who will be responsible for the provision of midwifery care. It was considered that the named midwife should be comfortable practising in both hospital and community.

It was stressed that midwives are able to be responsible for providing and arranging all the maternity care for women with uncomplicated pregnancies, and that legally midwives are able to practise independently. The duplication of work by professionals was considered a key problem that required concerted action in the interests of all concerned - and in order to facilitate the most effective use of resources.

Continuity of carer was seen as being a fundamental principle underpinning woman-centred care by many of the individuals and groups who provided evidence to the Group. This principle supported by the Group was exemplified through the following statement *"Throughout her pregnancy, and most particularly during labour, the woman should be cared for by people who are familiar to her and aware of her plans for delivery "*(5:6).

Another important point that was made related to the conclusion of the Group that past changes in the organisation of maternity care have resulted in midwives working in a fragmented way, tending to specialise in particular aspects of care rather than providing total care to a group of women.

Emphasis was placed on the need for consumers to have a key role in the planning and monitoring of services, to ensure they are accessible and acceptable to the local population. The need to improve communication at all levels within the service was very strongly identified.

The Group ended the report by incorporating the underlying principles of choice, continuity and control for women into ten key indicators of success, which were considered to be realistic targets to be achieved nationally within 5 years.

Since the publication of the report there has been extensive coverage in the professional press regarding the potential implications for professionals, service delivery and consumers. Many interpretations have been made of issues discussed in the report, not always an accurate reflection of what was actually written. This may reflect the strength of feeling about professional involvement, and perhaps ownership and control, that has developed in relation to maternity service provision. Not only are there issues related to medical versus 'other health specialist' input into the service (as in many 'nurse-doctor' situations, with all its attendant conflicts and demarcation disputes), there is also further potential for conflict in relation to the extent to which pregnancy and childbirth should be viewed essentially as a normal, healthy life event - or whether the potential for complications justifies medical involvement in all cases. A review of the literature shows quite clearly that this dichotomy still exists in some quarters, despite recent developments to promote more constructive working(see 21,111-112).

The most proliferative coverage regarding Changing Childbirth has occurred in the midwifery press, undoubtedly due to impact of the implementation of the report on midwives. However, Changing Childbirth has far reaching consequences for the medical profession as well, and although there has been some discussion of relevant issues in the medical press, the scale of the coverage and the extent of the debate has been limited. In fact, it has been suggested by Cardale(1994) that the passivity of the medical profession may be one of the most difficult obstacles for midwives to overcome in developing their role in relation to Changing Childbirth. She postulates that for the profession as a whole, it may be that *"a more effective way of opposing the midwives' increased control of the maternity services is to sit back in anticipation that the stumbling blocks encountered by midwives in bringing about changes will be insurmountable"*(84:60).

In their individual responses to Changing Childbirth, The English National Board for Nursing, Midwifery and Health Visiting (ENB), the Royal College of Midwives (RCM) and the United Kingdom Central Council for Nursing, Midwifery and

Health Visiting (UKCC), all strongly supported the fundamental principle of woman-centred care. The full use of the skills and knowledge of midwives was stressed, and the move towards midwifery involvement in alternative types of care, such as community based care was supported(82,86,151).

The Royal College of Obstetricians and Gynaecologists (RCOG) welcomed most of the recommendations in the report, but indicated a number of areas of concern and dissent. For example, concern was expressed that suggestions for changes in certain areas had not been scientifically tested. A further concern related to the perceived lack of attention to the needs of the unborn child. It was considered that equal attention should be given to the well-being of the fetus and the mother. The College supported the independence of the midwife as a practitioner but did not recommend midwife only care. It was considered that this practice should be tested. Particular concern was expressed in relation to possible complications in early pregnancy in areas that are not usually dealt with by midwives(85).

The appropriateness of the recommendations and indicators of success, outlined in Changing Childbirth have been the source of much debate, for several reasons. The extent to which they are actually based on sound evidence has been called into question - mainly by medical professionals - one comment relating to the fact that the *"report is predominantly written in the language of rhetoric rather than of science"*(97,1072).

Further concerns have been raised about the apparent conflict of delivering a woman-centred service at local level based on 'indicators of success' set nationally. However, those involved in constructing the report take the view that specific targets should be set at local level to reflect identified need - the indicators of success should be used to assess a national picture, with scope for variation within units.

Whether the indicators of success are based on appropriate evidence depends on what is meant by 'appropriate evidence'. There is not really any doubt that women, unsurprisingly, want a responsive, flexible service. Where the uncertainty comes in relates to the best way of ensuring the delivery of such a service. There is not unanimous agreement that all the indicators of success will promote their ultimate aim.

Another point of significance here relates to the lack of standardisation in the way the indicators are likely to be monitored - agreed definitions of terms have not been issued nationally, leaving the possibility that data will be collated and interpreted in a variety of ways(see 113).

Furthermore, there is a need to take care when assessing the potential impact of the implementation of the indicators, as they may not necessarily indicate that the service is providing woman-centred care. For example, Jackson(1995) has pointed out that "*...a woman could be carrying her own notes and not understand what is written in them, know the name of her midwife but not feel comfortable with her, or know the lead professional but not like them.....*"(98:398).

A further point of considerable significance relates to the extent to which women really can have choice and control over issues affecting their health. Much attention has been paid in the literature regarding the potential effects of social and economic factors on all areas of life, with consequent effects on health(100,101). Some women will be in a relatively disadvantaged position in relation to exercising choice and control over their lives. Until fundamental issues are addressed within society, equity of choice will not occur for all women, whether or not the indicators of success outlined in Changing Childbirth are achieved nationally. Of further relevance here is the difficulty that purchasers and providers are going to have trying to make sure that the service really is based on what all sections of the local population want. Particular concern may well arise in terms of the feasibility of finding out what the most frightened and vulnerable women in society need and want. What methods and resources are going to be needed to get a better understanding of this, and will adequate resources be available in the light of conflicting demands on the service even if appropriate methods can be identified?

Obviously, it was not within the remit of the Expert Group to specifically address broader structural and societal issues which impinge on equity, choice and control in health matters, but the impact of such fundamental concepts cannot be ignored by those planning or delivering the service, and the extent to which national indicators are achieved may only be a partial indicator of the extent to which a truly accessible, acceptable and equitable service has been provided.

Another significant development that will affect the way in which Changing Childbirth will be delivered, is the NHS reforms, including NHS Trusts, the purchaser/provider situation, GP contracts and GP fundholding. There is a growing literature focusing on the ideology underpinning these developments, and the implications for service delivery(158,102,107).

One important issue of the NHS reforms relates to the impact on resource allocation. Resourcing decisions will have an important knock-on effect on the implementation of Changing Childbirth. There are wide variations in size, geographical and demographic situation of obstetric units. This will affect the choices available to purchasers and providers regarding service provision. It might not always be feasible to have several systems of care available in one area, such as low dependency midwifery units and large maternity departments, but mothers in the locality may request both, depending on individual circumstances(97). The lack of comparable data sets regarding the costs and effectiveness of different types of maternity care causes a particular problem - leading to many purchasing decisions being made largely in the dark. It has been further suggested that the ability to 'pool risks' will diminish as budgets are devolved to small purchasing populations and provider units, leading possibly to a mis-match between local community need/choice and service provision(see 105). Furthermore, as has recently been pointed out defining, agreeing and measuring any outcomes pertaining to quality of care in the NHS is fraught with all manner of problems(102,104) although, on the positive side, a considerable amount of evidence has been amassed over recent years in relation to the delivery of effective care in pregnancy and childbirth(114-115).

The fact remains, however that despite other developments, this is the first time in the history of the NHS that a policy initiative has so strongly endorsed the drive for a consumer oriented service. Such innovation will inevitably raise fundamental questions, not all of which will have the prospect of immediate redress, some of which may never find answers which satisfy everyone. It may be that changes will need to be made as research and practice develop. In the meantime, there will continue to be many challenges to be met, the significance of which cannot be underestimated, as the extent to which any policy initiative will be successful must depend heavily on those delivering care. In this case, due to the key role of midwives in delivering the care proposed, and the remit of this study to focus on the role and responsibilities of midwives, an overview of some issues fundamental to the midwifery profession have been outlined below.

4.2 The Current Grading Structure In Midwifery

Issues related to grading structure and remuneration of midwives in relation to their role and responsibilities in implementing the care proposed by Changing Childbirth, has been extensively reported in the midwifery press.

It was acknowledged in Changing Childbirth that midwives terms of employment, including remuneration may need to be reviewed as more responsibility is accepted(5). Although the report was published in 1993, it is obvious that midwives still felt that their terms and conditions of employment had not been adequately addressed by the spring of 1995 when an RCM ballot of members indicated support for a change in the 'no industrial action' policy(see 89,109). Since then developments have included negotiations between the RCM and the National Health Service Executive (NHSE), which have produced a 'deal' whereby all midwives should be on a minimum remuneration equivalent to F or G grade, including those on part-time or job-share contracts. The RCM also wants the introduction of a new midwifery pay structure, different from nurses, which recognises the responsibilities of the profession in relation to Changing Childbirth. However, the profession is still not united in welcoming these developments as the way forward. Concerns have been expressed that any deals negotiated will not be legally enforced and local trusts may ignore guidance from the NHSE(90).

It is interesting to note that despite the attention paid by midwives, managers and policy makers alike, in relation to the potential impact of the midwifery grading structure, there has been remarkably little evaluative work in relation to the types of activities actually undertaken by midwives and the quality and outcomes of care delivered, in relation to grade. Various studies have reported on the effects of grading/skill-mix in the health service, but these have tended to relate to the nursing and health visiting professions(93).

Buchan and Stock(1990) reported some interesting findings in relation to midwives careers and grading issues. There were regional variations in relation to midwifery grading, with staff in lower graded posts much more likely to express dissatisfaction. Community midwifery was generally considered to be more likely to provide the type of experiences important to midwives(94).

Contemporary research data is clearly required concerning the role and responsibilities of midwives in relation to current grading structures, full/part-time status; and practice base (community/hospital/both settings). Such information will provide a much needed picture on what midwives are actually doing, what their development needs might be, how grading and remuneration issues might best be taken forward, and how local services might be most appropriately developed in relation to midwifery. The current study has provided some information in this respect in relation to the role and responsibilities of midwives. The findings and the potential implications for practice have been discussed in Chapters 3 to 8.

The next section focuses specifically on the scope of practice of midwives in the United Kingdom followed by a look at the evidence that is currently available, or being obtained regarding the types of maternity care provided and the midwives role within these.

5. THE SPHERE OF MIDWIFERY PRACTICE IN THE UNITED KINGDOM

5.1 Role and Responsibilities of Midwives

The literature regarding the role and responsibilities of the midwife indicates what an incredibly broad and complex remit midwives have been charged with. There is a wealth of information about the many aspects of the role. Often discrete aspects of the role are described, with a focus on the depth of knowledge and skill required in that particular area - providing an overall picture of the need for a highly competent, multi-skilled professional who is able to turn her hand to any one of a vast range of skills at anytime, depending on the need of those she is working with.

The Midwife's Code of Practice(9) provides a long definition of a midwife(p4), followed by the 'activities' of the midwife, which leaves the scope of practice in some areas rather open to interpretation in terms of where a midwife's responsibility might begin and end.

The last major national study that was undertaken regarding the role and responsibilities of midwives in England and Wales was reported in 1983 (over 5,000 midwives were included in the study).

A substantial proportion of midwives practised in situations in which they were not required to exercise fully the degree of clinical responsibility for which the midwife is trained and this was particularly the case with regard to antenatal care. Medical staff were significantly less likely than midwives to indicate that midwives were the ones making decisions concerning normal antepartum and intrapartum care. Those midwives who did fully exercise their clinical responsibility differed significantly by the type of practice situation in which they worked. In addition, duplication of midwifery and medical roles was noted(7).

Another study of relevance is the Policy and Practice in Midwifery Study which was carried out across England in 1984. The findings also indicated that the work circumstances of midwives varied considerably. The degree of involvement of senior midwives in policy making was subject to wide variation, as were policies affecting the day to day work of midwives. Particular attention was drawn to the inconsistency and conflicting advice inherent in policies in relation to the care of breastfeeding women and the policies related to food and drink during labour(13,121, 122).

These are the most comprehensive studies focusing on the role and responsibilities of midwives in England, although the literature includes an abundance of other information regarding specific aspects, or approaches to the role. For example, numerous studies (carried out in the UK), of variable size, methodology and quality are listed in the various reports of The Midwifery Research Database which have been compiled on a regular basis since 1988. Studies cover a broad range of clinical, educational, management and historical issues. Due to the vast range of methods used and topics investigated, it is not possible to summarise key findings, or determine national trends with any degree of reliability, but it is of interest to note that the most frequently mentioned clinical topics have included breastfeeding, labour, antenatal care and perineal care. Studies related to midwifery education and the experience of the consumer have increased over time, perhaps reflecting current policy developments(123).

It is also noteworthy that midwives have been directly involved in carrying out many of the studies, which may be indicative of the extent of coverage in midwifery books and journals encouraging the further development of midwifery as a 'research based' profession. However, not all of it advocates that there should be widespread involvement in research studies by midwives, rather it is the responsibility of midwives to ensure their practice is adequately informed by appropriate evidence. This does not happen universally by any means - despite gallant efforts by profession leaders - for which a plethora of potential factors have been identified, at structural, educational, organisational and individual levels(see 124-126).

5.2 Communication and Consumer Satisfaction with Maternity Provision

Many other facets of the midwife's role have been variously described in the literature, although in less measure than the clinical aspects, which does not mean that they are less important elements of the role, as much of the consumer literature, and Changing Childbirth demonstrates. Good communication in its broadest sense, is clearly a core element of effective midwifery practice(6,133-135,143-6). The Expert Group responsible for Changing Childbirth(5), made a particular point of noting that poor communication was evident at all levels within the service.

Oakley(1989), following a review of social intervention studies in pregnancy concluded that *"communication increases women's 'mastery' of their childbirth experiences"*(136:218). She goes on to discuss the potential influence of counselling and/or non-specific social support on a range of pregnancy outcomes. Social support is defined by Oakley as the *'provision of a non-judgmental listening ear, discussing with women their pregnancy needs, giving information when asked to, and carrying out referrals when appropriate to other health and welfare workers and voluntary and statutory agencies'*(168:31-32). Several other definitions of social support have also been provided in the literature, usually with a more clearly defined focus(e.g. 69). Oakley cites the findings from various studies to support her hypothesis, including her own work, based on a randomised controlled trial(133,137). Several other trials also support the tenor of Oakley et al's(1990) findings, in relation to the positive effects of sensitive and responsive care(e.g. 138-140), although the differences in methodologies used is striking, and not all the evidence points in the same direction by any means.

In addition to the intervention approaches, there is also a fairly substantial literature regarding the views of consumers about a range of aspects related to maternity service provision. The importance of effective communication has been identified by numerous studies, despite the use of various methodologies(35-41).

Obviously, the development of relationships between professionals and consumers is a complex area, and no one theoretical perspective will be able to satisfactorily explain all the situations that might arise. However, various ideological and theoretical perspectives from the literature may aid an understanding of factors that affect the basis and development of relationships between professionals and consumers. For example, ideas about the circumstances in which motherhood should occur may be very pervasive throughout society, thereby demonstrating how constructions of knowledge may articulate with established power relationships(43-46).

Leading on from the above discussions regarding communication, the literature indicates that women do not all want the same things from the service(29,31).

However, appropriate 'choice' comes across as being a key element of responsive care. Examples of issues where women have expressed a desire for choice include control over antenatal screening, the wish to be informed about potential problems antenatally, the extent to which technology and intervention methods are used during labour, and preference for length of stay in hospital post-natally(e.g. see 65,14,66,30-32).

Another issue that features prominently in the literature regarding satisfaction with the maternity service is 'continuity of carer'. Many studies have focused on this issue over recent years, but again, complex methodological issues make it difficult to draw clear conclusions, as different methods have been used with various populations and definitions of terminology regarding continuity of carer and continuity of care vary. The question arises as to whether it should be continuity of carers (i.e. provided by one person) or continuity of caring (i.e. underpinned by shared philosophies so that all those in contact with women provide the same care?). Murphy-Black(1993) postulates that another interpretation is that continuity of care is achieved by individualised care or that individualised care compensates for the large number of staff giving care(64:8).

On the whole, the findings indicate that continuity of carer is an important component of responsive care to some women(33-5). Of course, as has been touched on above, the continuity of carer issue may not, of itself lead to responsive, high quality care being provided. Clearly, a wide range of factors will contribute to the type of care that is delivered. An issue that is likely to have a major influence on the satisfaction of mothers with the care provided, is the type of interaction that is developed between practitioners and consumers. For example, some work has indicated that just getting to know a small number of staff may not help women much if staff attitudes are stereotyped or unsupportive(39).

A further important issue has been raised by Currell(1991), who stresses the importance of care being organised in an individual and focused way, so that all encounters with staff contribute to the whole. Currell postulates that *"this approach to the organisation of care will inevitably take into account the woman and her expectations beyond the limits of the maternity services. It will place the midwife in her true role of being 'with woman', as a facilitator, helping the woman to achieve her own goals for herself and her baby"*(38:37). However, Currell also draws attention to the fact that more research is required concerning the organisation of systems of maternity care, in relation to the effects of the care provided both on the mother, and on the professionals who are involved in care provision.

One further point that has emerged in the literature relates to the tendency of women to report satisfaction with whatever type of care they are provided with. There may be many complex reasons for this situation. These may include a lack of knowledge/confidence regarding use of the complaints system and a belief that whatever system of care is provided must be well thought out and therefore likely to be the best option. Porter and Macintyre(1984) discuss the methodological challenges that obviously arise in this context when consumer studies are being carried out(147).

5.3 Counselling

In addition to the broad issues of communication and social support outlined above, considerable emphasis is also paid in the literature to the importance of more specific counselling in relation to maternity service provision. This has particular significance for the role of midwives, particularly in the light of the emphasis in the Midwives Code of Practice on the involvement of midwives in 'health counselling and education'(9)

Some of the salient issues that may well arise during midwives practise are discussed by Hunter(1994) and Sherr(1995)(152-3). These include the importance of acknowledging that 'counselling' may mean many different things to different people and problems may consequently arise in many areas related to theories underpinning the approach, the efficiency with which interventions occur, the available education and the client's readiness to avail themselves of the facilities offered. Hunter(1994) draws attention to the growing body of evidence attesting to the benefits resulting from good communication and counselling in obstetrics, with particular emphasis on the importance of adequate training, supervision and support for the 'counsellor'. The need to recognise the limits of individual skill and resources and to work within definite boundaries of time, role and responsibility are clearly acknowledged. The literature confirms the importance of this, in relation to the potential role of midwives in a wide range of counselling activities including bereavement, smoking cessation, ante-natal screening, the breaking of bad news, HIV/AIDS, anxiety and depression, to cite but a few(154-5,65,153).

Obviously, the type and level of input will be of crucial importance in this context, with all midwives being expected to have a basic level of knowledge and skill, but the point at which further education or referral will be required is not always obvious and mothers and midwives alike may be exposed to potential dangers if the necessary resources and support are not widely available at local level. For example, Hajek and Owen(1994) found that midwives do not feel sufficiently equipped for specialist interventions with smokers and are aware of offering an alternative which they believe is less than adequate. They suggest that *"an obvious remedy for the future would be to include sessions on smoking behaviour.... and on intervention techniques and skills during initial midwifery training as well as post-registration"*(155:466).

A further point that may be important here relates to the potential distinction between counselling and counselling skills. Taylor(1995) cites the British Association for Counselling's description of counselling as a *"process which involves the helping skills of caring, listening and reflecting. It's based on listening to the client and a trusting relationship between the client and the counsellor. It's not the same as advice giving. A counsellor will be supportive, but will give little or no direct advice, since the aim of counselling is to help us develop our own insight into our problems"*(164:67-8). Taylor postulates that this is a bland description which does not seem to touch on the skills necessary to practise counselling. In her view, *counselling skills,* include 'caring, listening and reflecting' and she postulates that a midwife conducting a booking interview, for example, will use them. She goes on to say that *counselling* is marked by a clear bounded structure, and by a contract between counsellor and client. Clearly, just by considering these two approaches to defining counselling, some of the complexities around the issues become apparent, which will have far reaching implications for midwives engaging in 'health counselling' as part of their remit as defined by the Midwife's Code of Practice(9).

5.4 Accountability

In relation to the role and responsibilities of midwives, accountability will be of obvious significance, and not surprisingly a considerable amount of attention has been paid to its potential implications in the midwifery literature. The Midwife's Code of Practice states that *"Each midwife as a practitioner of midwifery is accountable for her own practice in whatever environment she practises"*(9:3). There follows much debate within and outside the profession with 'autonomous' and 'independent' practice frequently discussed, and variously determined.

Sleep(1992) postulates that *"Midwives are vociferous over the issue of obstetric/male dominance but if that was to vanish tomorrow the hierarchical structure within the midwifery profession would almost certainly remain. Midwives are prone to the indulgence of self denial: "it was not my fault...I was told to do it...that is someone else's responsibility". In the next breath they talk of autonomy and accountability"*. She goes on to say that *"We cannot have it both ways. To be accountable means that actions must be explainable, defensible and based on knowledge rather than tradition, authority or myth"*(125:1468).

However, grey areas will always exist as midwifery is not and can never be an exact science - prospective determination of individual risk/outcome is not possible. A further complication arises in relation to apparently conflicting evidence in numerous cases. Despite efforts to ensure that research studies are carried out with the utmost rigour, and reviews of effectiveness are available for use by the professions (e.g. NHS Centre for Reviews and Dissemination, Cochrane Database), midwives will inevitably have to live with a degree of uncertainty.

Furthermore, the issues related to litigation in the maternity service are of considerable importance in this context. Much has recently been written regarding possible litigation action in maternity cases and the potential involvement of midwives in this process. In her recent book on The Legal Aspects of Midwifery, Dimond(1994) discusses the concept of vicarious liability and concludes that it would be usual in the case of an employed midwife for the employer to be sued in the event of the midwife's negligence (a more complex situation arises in relation to midwives not directly employed by another agency, such as independent midwives). Dimond goes on to say that *"Whilst the doctrine of vicarious liability enables the victim of negligence to obtain compensation, it does not necessarily deprive the employer of his rights against the negligent employee....".* *(162 122)*

Midwives obviously carry a heavy responsibility in relation to the issues outlined above. Even though it appears (so far) that they will not be individually liable in litigation cases there may well be repercussions at local level in respect of employers taking action on the basis of breach of contract in relation to negligence. Action may also be taken by the statutory body regulating midwifery practice.

5.5 Midwifery Supervision

The concept of supervision in midwifery is the chief mechanism in place aimed at providing each midwife with support as a colleague, counsellor and adviser, and promoting positive working relationships, in order to fulfil the common aim of safety in practice and care(9).

Supervision in midwifery has a long history. It came into being as a consequence of the 1902 Midwives Act to ensure professional regulation of midwives to protect the public. Various developments have occurred over the years and it has recently been pointed out that the supervision of midwives has developed more during the last 5 years than at any other time since its inception(142:83).

A variety of opinions have been expressed in the midwifery literature in relation to the concept of supervision. For example, Demilew(1995) believes that supervision is the key component towards accountable excellent practice. She sees supervision as having a key role to play in ensuring quality of service provision, and enabling midwives to practice their role fully(167). Mayes(1993) concludes that *"the process of supervision of midwives provides a safety mechanism which is available as a resource for midwives and which assures clients of a reliable, competent standard of care, consistent with the professional codes and regulations"*(214:141).

However, the concept is still challenged by some as an oppressive tool that undermines midwives autonomy(165). It has also been pointed out that the dual responsibilities of the supervisor in relation to guiding and befriending midwives and protecting the public against bad practitioners may not sit well together. Traditionally many supervisors have also held a managerial role simultaneously, although recent developments have relaxed the criteria so that it will be easier for non-managerial staff to become supervisors.

Plans are being made for the supervision concept to be developed further, and the ENB is commissioning some relevant research in the area. There is very little evidence available regarding the most effective model(s) of supervision in relation to providing support and counselling to midwives, and in promoting the provision of optimum care.

6. SYSTEMS OF MIDWIFERY CARE

6.1 Midwifery Care

In this section the focus moves from the specific role and responsibilities of midwives to the broader context in which midwifery care is delivered. An enormous amount has been written about the various systems that are in place countrywide to deliver midwifery care, some of it research based, a substantial amount of it based on the opinion of those delivering, and occasionally those receiving the service. The picture in many senses remains confused in certain areas, and due to the dynamic nature of service provision for a multiplicity of reasons, will probably always be so to a greater or lesser extent. However, it all makes for interesting reading and the purpose of this section is to summarise some of the key issues that are currently of interest in relation to provision of the midwifery service in the United Kingdom (UK).

Wraight et al(1993), following a study of maternity units in England and Wales, indicated that developments in midwifery care over the past decade have resulted in several innovative forms of midwifery organisation, in an attempt to provide greater continuity of care, and carer. Findings of the study showed that numerous models of care were operating in various settings across the UK, including home births, shared care, birth plans, individual care plans, domino schemes, case allocation, midwifery process and team midwifery(3).

Numerous studies have been reported in the literature regarding various forms of providing midwifery care. Amongst commonly cited studies based in the UK are the Know Your Midwife Scheme (KYM), the Newcastle Community Midwifery Care Project, the Kidlington Team Midwifery Scheme, the Social Support in Pregnancy Study, One to One Midwifery Practice, the Midwifery Development Unit based at the Glasgow Royal Maternity Hospital, and a comparison between a midwife managed delivery unit and consultant led care in Aberdeen(169,175,176,133,63,170,171). In addition, many other reports of innovative ways of providing midwifery care continue to appear in the literature on a regular basis (e.g. 172-174).

Various methods have been used to deliver and evaluate the care provided with the inevitable corollary that it is difficult to draw hard and fast conclusions about the outcomes of the care provided. However, certain themes seem to be emerging. For example, a number of studies outlined above have reported increased satisfaction with various aspects related to the provision of the midwifery service amongst mothers who received a variety of midwifery interventions, including having all care provided by a small team of midwives, having enhanced support from a pair of midwives, social support from one midwife; and care within a midwifery development unit, (with an average of 10 carers), as opposed to care in a consultant-led unit, with an average of 17 carers(169,175,168,170).

In addition, some effects of midwifery interventions on mothers being more likely to go into spontaneous labour(169,170), have less or natural methods of pain relief and be less likely to have an episiotomy have also been noted(169-171,175-176). However, not all studies have found consistent results in all respects, particularly with regard to neonatal and maternal outcomes. Brief reference to international work indicates a broadly similar picture to the one outlined here for studies undertaken in the UK(177-179). It is therefore not possible at this stage, to say with any degree of certainty which particular midwifery scheme will be of most benefit to a specific group of women; it may be that certain benefits will be derived from *any* system of care, provided that the woman feels her needs are being listened to and addressed.

A further point of considerable importance relates to the findings of Wraight et al(1993) and Meldrum et al(1994) that there is enormous variation regarding the way in which systems of care and aspects of midwifery care are defined. The importance of a common understanding of what is meant by the terminology surrounding the organisation and provision of maternity services in relation to purchaser/provider contracts and the work undertaken by practitioners and researchers is stressed by Meldrum et al(113).

6.2 General Practitioner Units and Home Births

The evidence regarding the number of women who would like to have a home-birth is not clear, but findings consistently indicate an unmet demand(see 186). Young(1994) concludes that there is probably some heavy dissuading pressure put on nearly all women requesting home birth(188), as currently 98% of women give birth in consultant-led units. However, it is not actually possible to determine just how many women would want a home-birth if the option actually was more widely available.

The evidence regarding safety and place of birth is rather confusing, and reliable data sets are lacking. However, the evidence that is available generally shows no significant difference in outcome for obstetrically low risk mothers (maternal mortality, perinatal mortality, morbidity) between large maternity hospitals, primary care units and home(190-192).

The Changing Childbirth Expert Group concluded that there is no clear answer as regards safety of place of birth and indicated the importance of women being provided with as much accurate and objective information as possible.

Obviously, an important point in relation to the role and responsibilities of midwives is the extent to which midwives are able to provide care in a range of settings and more research data will clearly be required in this respect as very little information is currently available regarding the range of skills used/required by midwives providing care in alternative settings.

6.3 Costs of Maternity Care

Effective, efficient, cost-effective choices can only be made when the full facts are available. Robinson(1993) indicates that cost benefit analysis is probably the only truly comprehensive method of economic evaluation of health care(193). Cost-benefit analysis aims to assess the 'worthwhileness' of an intervention by considering a whole range of factors including outcomes and outputs. These issues have been widely discussed in the literature(see 67). Despite the many complexities inherent in assessing the costs of maternity care, a clear need to obtain more robust data to inform service planning remains(see 194).

There were no contemporary data available to cost the changes proposed in Changing Childbirth, and McFarlane(1994) has indicated that the assumption that community-based care can be provided more cheaply than hospital-based care has been challenged in other health care settings. Some estimates have been put forward regarding the costs of various forms of maternity service provision, but there is no comprehensive reliable data available to inform service planning at national level. The little information that does exist has not been collected systematically or using comparable methods and therefore conflicting findings have been reported regarding whether hospital based care or various forms of community based care are more or less expensive(see 182-185).

In the recommendations outlined following a Study Group(1994), comprising key members of the midwifery and medical professions, formal, rigorous, evaluation of pilot studies of GP fundholders purchasing maternity care was considered to be important, as was more research into alternative models for delivery of care(196). Several studies are currently being planned or in progress that will add considerably to the available evidence regarding aspects of midwifery service provision(see 204-5).

Obviously, the preparedness of midwives to provide optimum care in the context of the complex issues outlined above will be of paramount importance. In this respect, the educational needs of the workforce will require careful analysis. The next section addresses some of the key issues currently under debate.

7. CONTINUING EDUCATION FOR MIDWIVES

When the role and responsibilities of midwives are being developed, particular attention needs to be paid to the nature of midwifery education. Emphasis is placed on a balance of clinical skills and knowledge, the need for intellectual development, knowledge of the human sciences and the need to use scientific evidence in practice. A high premium is placed on interpersonal and communication skills. All students are expected to become competent practising in both the community and hospital before registration as a midwife, and to be able to undertake the "activities of a midwife" as outlined in the Midwife's Code of Practice(9). In addition, midwives who wish to notify their intention to practise are expected to fulfil the statutory refresher requirement at the current time(47). However, in the future this requirement will no longer be mandatory in its current form and midwives will have to fulfil their obligations under Post Registration Education and Practice (PREP)(197), which places greater emphasis on the midwife identifying her own needs for professional growth, and being expected to find appropriate updating opportunities based on individual need.

There are currently three main types of programmes of education for admission to Part 10 of the UKCC Register, all of which are required to prepare midwives to practise in accordance with the Midwife's Code of Practice and Midwives Rules(9,47). The Midwives Rules outline the outcomes that students must achieve through a programme of education, and there has been much discussion and debate regarding the various types of education programmes for midwives and their potential, desired and actual outcomes(e.g. 198-201).

However, despite developments in initial education programmes, concern is still often expressed that many midwives within the NHS fail to carry out the total role of the midwife. The Expert Group responsible for Changing Childbirth specifically addressed the needs of midwives who have been in practice for some time without undertaking their full role. The Group suggested that these midwives may require support for professional development. In addition, the ENB in its response to Changing Childbirth, indicated that *"Midwives will need educational programmes which equip them with the knowledge, skill and confidence to initiate and participate in new dimensions of care"*(82). The need to take steps to promote the effective integration of theory and practice have been identified if health professionals are to provide the type of care envisaged in recent policy and practice related reports(e.g. 203).

Furthermore, emphasis has often recently been placed on the potential value of interprofessional involvement in education in facilitating broader dimensions of service provision. Numerous difficulties have been identified by the various organisations involved in education, but clear attempts are being made to find appropriate ways of promoting effective interdisciplinary education(21).

Many of the issues outlined in the above sections of the review indicate the current context of practice, and potential areas for the continuing education of midwives. These may include a broad-based knowledge of the contribution that individual and contextual factors may have on dimensions of care that are delivered in the dynamic framework within which health care provision is currently delivered.

Midwives are required to act as accountable practitioners. Therefore, each midwife is responsible for maintaining competence to practise. Clearly, managers and supervisors will also have a role in the continuing education of the workforce. The supervisor of midwives is responsible for overseeing professional development as a means of maintaining and improving clinical practice and standards of care. There has not been much recent research attention paid to the views of midwives, supervisors or managers regarding the continuing educational needs of midwives at national level, and further work in this area would allow for the development of a broader perspective in relation to the most appropriate ways of addressing future need. The current study has provided some new data in this respect.

7.1 Methods of Learning

Furneaux(1995) points out that *"the complex nature of the skills to be developed to meet 'Changing Childbirth' recommendations will require education practices that are innovative and that recognise the unique characteristics of adult learning"*(48 45). Much of the literature that focuses on the most effective means of education for adults/professionals, draws attention to the importance of reflection on practice, reflecting in action, and the promotion of enquiry based learning, using analytical techniques(see 49-51). However, complexities concerning such issues have been identified by some writers(202,203), and will need to be considered within the framework that is used to promote the continuing education of the profession.

There are many potential methods through which continuing education may be delivered. Initially, an individual assessment of need will be required through appropriate means. Many such methods are likely to be available at local level (e.g. development of professional portfolios; educational needs analysis by individuals, perhaps in conjunction with supervisors/managers/tutors). Once individual need has been determined, it will be important for programmes of study to be flexible enough to meet those needs. This may include modular programmes of learning, credit accumulation transfer schemes, scope for accreditation of prior learning/experiential learning, (APL/APEL); and meeting the criteria of ENB Higher Award/PREP.

Clearly, it is imperative that the most effective continuing education is delivered within an appropriate context. Many factors currently affect the type of initiatives that will be available for the continuing education of midwives, including resourcing issues (financial and time related). At the current time it is difficult to determine, with any degree of certainty, the relative effectiveness of various continuing education methods. However, it is likely that distance and open learning methods, can begin to address some of the issues outlined above, related to resourcing and flexibility (although it will not be suitable for learning all midwifery related skills, such as clinical skills).

'Open learning' is not a definitive term, but it may be used to describe a range of strategies within which the depth, breadth, amount and mode of study that will be undertaken by an individual may be determined. In terms of the flexibility element, Clark and Robinson(1994) postulate that *"it is the control over the essential elements of the curriculum in terms of the content and assessment which shift the locus of control substantially away from the teacher towards the learner"*(54:259). With regard to 'distance learning', Clark and Robinson indicate that *"...it is possible to define teaching activities that use technology to enable the student to 'activate' the teaching at some point in time and space distance to the teacher as distance teaching. In order to emphasise the activity of the student, the whole process is often referred to as distance learning"*(54:258).

When open and/or distance learning methods are being used, various mechanisms need to be put into place to ensure that programmes are as effective as possible in meeting learner need. In this context, attention needs to be paid to many issues, including: curriculum and course planning, academic and professional level, learner support/access mechanisms, validation, and programme monitoring and evaluation(55).

It is important to acknowledge that, although, open and distance learning methods, are becoming more commonly used in nursing, midwifery and health visiting education, there has been little evaluation regarding the most appropriate development of materials and support systems, nor the effectiveness of such methods. Clearly, there is a need for further work to be comprehensively and systematically undertaken(see 54).

As well as having access to appropriate continuing education opportunities, it will be important for professionals to have the motivation to make use of such opportunities. Theories of motivation and adult learning may help to explain why adults participate/do not participate in continuing education, and the ways in which they might best learn(57-61). Reference to relevant theoretical perspectives when developing curricula will help to ensure that education initiatives will be both accessible, and appropriate to the profession(56). Further information regarding the principles underpinning continuing professional education and the way in which they have been operationalised in relation to developing an educational package for midwives through this project have been outlined in Chapter 2.

7.2 Potential for Further Study

It is apparent from the work discussed above, that a wealth of factors will affect the role and responsibilities of midwives, and the way that midwifery care is provided. It is true to say that relatively little research attention has been paid in recent years to many of the issues outlined in this review. It would, of course, be beyond the scope of any one study to consider in detail, the complexity of issues related to the delivery of the midwifery service.

However, there is a pressing need, particularly in the light of current policy trends, for a national study to be carried out in relation to the current role and responsibilities of midwives, the factors that influence the development of the role; and the ways in which continuing education initiatives might best be provided for the profession within the dynamic circumstances in which practice must occur. The last national study of the role and responsibilities of midwives was reported some twelve years ago(7). Major structural and organisational change have taken place in the intervening period, in both the health and education sectors.

In this context, the ENB commissioned the University of Greenwich to undertake a study with the following 3 aims:

(1) to establish the current role and responsibilities of midwives in a variety of settings with a range of client groups **(6 months),**

(2) to identify the changing educational needs of midwives to fulfil their future widened role and responsibilities within changing maternity services **(6 months),**

(3) to develop an educational package to facilitate midwives in responding to the requirements of their changing role and responsibilities **(one year).**

The rest of this report has focused on the methodology used for the study, the findings and an overview of the development of the educational package that has been produced on the basis of the research findings.

CHAPTER 2: METHODOLOGY AND DATA ANALYSIS STRATEGY

The methods used have been outlined in this chapter. A critique of the methods used for each aspect of the study has been included in the appropriate sections of the chapter.

1. AIM 1:

TO ESTABLISH THE CURRENT ROLE AND RESPONSIBILITIES OF MIDWIVES WORKING IN A VARIETY OF SETTINGS WITH A RANGE OF CLIENT GROUPS (6 months).

This section focuses on:

- the development of the methods for this part of the study
- the design of the research tools

1.1 Background to the Development of the Methods

It was important that the framework underpinning this study allowed for a detailed analysis of the current situation and an exploration of potential ways forward. The information generated from such an approach will be most useful if it reflects the dynamic experience of those who practice. Therefore, the formal testing of hypotheses was not considered appropriate, but key research questions were put forward for detailed exploration:

- What are the current role and responsibilities of midwives?
- What are the key factors that influence the scope of midwives practice?
- What are the developmental needs of practising midwives and how may these needs be most appropriately addressed?

It was considered that it would be important for information to be collected at national level that would allow a comprehensive picture of the prevailing situation to be built up regarding the current role and responsibilities of midwives.

In the light of the need to obtain a large, national data set within a limited period of time, it was considered that information would be best obtained via postal questionnaires. The use of questionnaires would allow information to be collected on a wide range of relevant topics from a large number of maternity units countrywide.

It was decided to include national samples of co-ordinating supervisors of midwives, midwives, obstetric consultants, registrars and general practitioners (GP's) in this phase of the study. The inclusion of these professional groups allowed for a comprehensive picture to be obtained regarding the role and responsibilities of midwives from the perspective of those who have key responsibility for maternity service provision. (The methods used to include consumers in the study have been discussed in Section 2.2).

1.2 Sampling Strategy

Using statistical methods, sample size calculations were carried out and representative samples were taken, as far as possible.

1.2.1 Co-ordinating supervisors of midwives (N=205)

A questionnaire was sent to every co-ordinating supervisor (supervisor) in England. Although there may not be a formal hierarchy amongst supervisors, as there are a considerable number of supervisors with whom the local supervising authority (LSA) needs to communicate, each NHS Trust/district has one supervisor through whom all communication between the LSA and local unit/s is normally conducted(166) Several terms are used for this supervisor including 'co-ordinating', 'key', 'prime' and 'corresponding'. For the purposes of this study the term 'co-ordinating' supervisor has been used. The co-ordinating supervisor is often, but not always, the Head of Midwifery for the maternity unit.

The co-ordinating supervisor was selected for inclusion in this study as she is one of the professionals at local level likely to have a broad knowledge of both policy and practice issues.

The sample was drawn through the Directory of Emergency and Special Care Units(1994). This directory was used as, at the time of sampling, it was the most recently compiled source of information that listed a key member of the midwifery service for all maternity units in England. On the occasions when the person listed was not the co-ordinating supervisor, they were asked to provide the research team with the relevant information in order that the supervisor might be approached.

1.2.2 Obstetric consultants (n=205), and registrars (n=196)

One consultant was selected at random from every maternity unit in England. Each consultant was asked to distribute a questionnaire to a registrar who had worked in obstetrics for at least 6 months. It was decided to include samples of consultants and registrars in order to obtain information from medical staff who work with midwives in a broad range of situations.

1.2.3 General Practitioners (GP's) (n=250)

A random sample of GP's across England was selected using local data sources that were used to compile a national database. Simple random sampling methods were employed. Participants were asked to complete the questionnaire in relation to the obstetric services offered by the practice.

1.2.4 Midwives (n=1100).

A national stratified random sample of midwives was selected. The strata that were selected (on the basis of the available literature and expert midwifery opinion) included:

- regional location (by NHS Region and geographical location within the region)
- grade of midwife
- size of maternity unit (in terms of the number of midwives employed).

There are no national databases available that contain the information required to select the type of sample outlined above. Therefore, every maternity unit in England (N=205) was asked to provide information to assist in the sampling procedure.

Chief Executives and Heads of Midwifery were requested to provide, in confidence, the following information for every midwife who had notified their intention to practise:

- name, workplace address, grade, full/part-time status, practice base (hospital only, community only or both hospital and community).

Where units were unable to provide all the information requested, alternative proposals were discussed with the managers concerned. For example, where the problem related to the units not wishing to provide the researchers with midwives names (which occurred in a small number of cases) it was suggested that Heads of Midwifery allocated each midwife a number, and kept a copy of the numbers allocated to each midwife. The researchers would then be provided with a list of numbers, for all midwives in the unit, with relevant information also available regarding grade, hours of work, community/hospital base etc. This allowed the researchers to contact a midwife through her identification number (ID). The potential implications of this process in relation to interpretation of the data obtained were considered when the data were being analysed in order to ascertain whether differences were apparent between the responses of midwives who had been approached by name and those that had been approached by ID (see Section 4, subsection 4.2).

(I) The representativeness of the sample

More than 90% of units provided the researchers with some information concerning the midwives employed by the unit. Seventy four percent of units provided information from which individual midwives could be selected. Where units did not provide information by which individual midwives could be selected, basic information regarding the overall structure of the midwifery service was requested (e.g. number and grades of midwives employed etc.), to assist in building up a national picture of the characteristics of the midwifery profession.

The ENB collected basic information in 1991/2 regarding the number and grading structure of midwives across England from all maternity units. Although this information was somewhat out of date by the time this study was undertaken (August 1994), the data were useful for comparative purposes. The data collected by the ENB and the information obtained for this study were largely consistent, in the light of recent grading changes in maternity units. The main differences between the two samples, related to more E grades, and less G grades in 1994, which is consistent with current health service trends. No other national data were available for comparative purposes(130).

(ii) Details of sampling procedure used for midwives

After careful consideration of the information that was obtained from maternity units, it was decided to include 60 units (from a total of 205) in the sample. This size sample allowed information to be obtained on a broad range of situations that exist countrywide (as many different systems of care were operating, within a large number of NHS Trusts); and to ensure that the grading structure of midwives and other key characteristics of the profession would be adequately reflected in the sampling process (e.g. practice base, full/part-time working).

Of the 60 units, 53 provided names of midwives. In the other 7 units, midwives were approached by identification number via the Head of Midwifery.

The number of units per NHS region was selected to represent the total number of units in each region (e.g. if 20% of all maternity units in the country were in region 1, 20% of the 60 units studied would have been selected from region 1).

The sample was further stratified by the size of the units (small, medium, large - in terms of the number of midwives employed; see below for further details). Again, the size of the units selected in a region reflected the overall structure of the size of the units in that region. Care was taken to ensure that the units chosen represented the urban/rural characteristics of the region. Within this framework, units chosen were selected using simple random sampling.

The reason why the sample was stratified by size in this way related to the fact that recent changes had been made to the structure of many maternity units as NHS Trusts were established. The size of NHS Trusts varies considerably. It was considered therefore, that it would be most appropriate to ensure that the sample was selected to reflect the structure of the units countrywide. This would increase the potential for a representative picture of the prevailing situation to be obtained.

It was decided to determine the size of units in relation to the mean number of midwives employed in the maternity units in England for which information was available (185 units). In this context, a small unit employed up to 70 midwives, a medium unit between 71 and 150 midwives, and a large unit more than 150 midwives. This allowed a reasonable framework for analysis of data by unit size.

Obviously, the way that size of unit has been determined for the purposes of this study is not 'absolute', but information has been obtained on the way midwives work in units where the number of midwives employed approximates to the national average, and is somewhat higher or lower than the average. This has provided a potentially useful framework for furthering understanding about the way in which care is provided in the broad range of units that currently exist countrywide.

The grading structure and number of midwives selected per unit was in proportion to the grading structure and size of the particular unit.

Once the sample had been stratified in the way outlined above, in order to ensure representativeness as far as possible, midwives were selected using simple random sampling within each strata.

To summarise, the stratification of the sample in the way outlined above allowed for a sample to be obtained reflecting the following characteristics of the midwife population: grade, practice base, full/part-time working. In addition, it was possible to select the number of units in each region in proportion to the total number of units countrywide, and also to ensure that the number of midwives selected in each region was representative of the total number of midwives in that region.

In addition, a questionnaire was sent to independent midwives in England if they were included in the Register of Independent Midwives, or if their name was provided by a supervisor at local level.

1.3 Sample Follow Up

Professionals who did not return questionnaires were followed up. Doctors and supervisors were followed up once by post. Midwives were followed up twice by post and by telephone if necessary. A different method of follow up was used for midwives as it became apparent that some questionnaires were not initially being received by midwives.

1.4 Overview Of Sampling Methods For Midwives

The procedure used for sampling the midwives was somewhat time consuming in relation to negotiating access to a large number of maternity units. However, there were considerable methodological advantages. For example, this methodology was likely to increase the potential for optimum response rates. It also allowed for data to be collected from different professional groups in the same unit for comparison purposes. Furthermore, stratification of the sample of midwives in the way outlined above was possible.

It is important to note that this sampling procedure was selected in order to provide the type of information that would be most useful for the purpose of developing an educational package for midwives. As very little recent information was available on the potential significance of the factors that affect midwives capacity to undertake various aspects of their role it was considered important that the data obtained would provide a sound basis for developing a package that would meet the needs of midwives from a broad range of backgrounds.

In order to protect the interests of potential respondents, it was clearly indicated to each midwife that participation was entirely voluntary and their responses would only be seen by the research team and treated in confidence. Direct contact with Chief Executives and Heads of Services ensured that they were aware of the information that was being collected about their service, and ensured that local ethical guidelines regarding collection of information from staff employed by the service could be observed.

1.5 Design of the Questionnaires

The literature and expert opinion obtained from Steering Committee members were used to decide on the issues that needed to be addressed in order to obtain a broad picture of the role and responsibilities of midwives, the factors that are likely to affect the extent to which midwives undertake their role, and their continuing educational needs.

For example, the literature outlined in Chapter 1 indicates that many complex factors are likely to affect the role and responsibilities of midwives, including the systems that are in place through which maternity care is provided, national and local policies and procedures, professional relationships, and the remit of midwives as defined by the UKCC. All these factors will be likely to affect midwives continuing education needs, and midwives confidence and competence to practise. These issues therefore formed the basis for the content of the questionnaire.

Once the initial drafts of the questionnaires had been completed, a 'pre-pilot' phase was carried out with each of the professional groups. A small number of relevant professionals were contacted with the 'pre-pilot' version with an explanation of the nature of the study, and the purpose of the questionnaire. They were asked to provide detailed feedback regarding the suitability of the questions to the professionals concerned, clarity, content, length and coverage of questionnaire, with scope for further comments.

A second draft was prepared in the light of the findings from the 'pre-pilot' phase. A pilot study was carried out with professionals from all the relevant groups.

As in the 'pre-pilot' phase, respondents were asked to comment extensively on an attached sheet once they had completed the questionnaire. Pilot study data were carefully considered when the questionnaire was being finalised.

1.5.1 Questionnaire content

All the versions of the questionnaire were kept as similar as possible for comparison purposes between professional groups.

The questionnaires consisted of a mixture of closed and open-ended questions providing a large amount of both quantitative and qualitative data. The key areas covered by the questionnaires included:

- maternity service provision,
- the role and responsibilities of midwives,
- perceived competency/confidence of midwives to undertake their full role,
- the continuing education and training needs of midwives and the most appropriate means for meeting outstanding need (supervisor and midwife versions only).

1.5.2 Reliability and validity

There has not been a major national study of the role and responsibilities of midwives for more than a decade. Many radical changes have taken place within the health service over recent years. Therefore, it was not possible to draw heavily on any other appropriate measures when questions were being written.

However, the available literature, the expertise of Steering Committee members, pre-pilot and pilot phases of the study helped to ensure that questions were appropriate regarding the issues covered and the way in which questions were asked.

The activities of a midwife are defined in the European Community Midwives Directive 80/155/EEC Article 4 (UKCC Midwives Code of Practice 1994)(9). Questions were designed around the extent to which midwives currently provide aspects of care in line with the Directive, and their level of confidence/competence to provide such care.

In addition, midwives also provide many other aspects of care, often referred to as the 'enhanced' role. From searching the literature and taking advice from appropriate experts (e.g. midwives, managers, statutory and professional bodies) a range of such activities emerged that were also included in the questionnaire.

Changing Childbirth(1993)(5), outlines ten key indicators of success for attainment within the maternity service. Many of these indicators have direct relevance to midwifery.

Therefore, questions were designed around the extent to which these indicators were being met/planned for, and reasons for non-implementation. In addition, questions were designed in relation to the stated aims/strategies/targets etc., outlined at local level for the delivery of the maternity service.

Such issues should have been 'valid' in so far as they represent the types of activities midwives are required by statute/policy directives to undertake, and/or are regularly involved with.

2. AIM 2:

TO IDENTIFY THE CHANGING EDUCATIONAL NEEDS OF MIDWIVES TO FULFIL THEIR FUTURE WIDENED ROLE AND RESPONSIBILITIES WITHIN THE CHANGING MATERNITY SERVICES (6 months)

This section focuses on:

- the methods used for this part of the study with the professionals/managers,
- the methods used for this part of the study with the consumers,

2.1 Methods with Professionals/Managers

2.1.1 Case study sites

It was decided to undertake case studies in 3 sites across England in order to follow up key issues raised through the questionnaire aspect of the study, and most importantly to inform the development of the educational package (see aim 3).

Three case study sites were chosen according to the following criteria:

- geographical location: north, central and south of England. Units serving an urban population, a rural population, and a mixed (urban/rural) population were chosen.
- type of population served. One unit served a fairly homogenous population in terms of social class background, the other 2 served more mixed populations. One area had a high proportion of Asian women resident in the locality.
- size of unit in terms of the number of midwives employed (small, medium, large).

Each site visited was managed by a Trust. Permission was obtained through the Chief Executive and Head of Midwifery at each site to undertake the case study.

2.1.2 Respondents

Appointments were made prior to the visits to the sites, with the following personnel:

- general managers (with responsibility for the maternity service),
- midwifery managers/supervisors.

The number of managers and supervisors interviewed at each site varied according to the management structure of the unit, but all those with key responsibility for the midwifery service were interviewed:

- one consultant per site (where possible, the consultant who had completed the questionnaire),
- between 1 and 3 GP's per site (depending on size of area covered, where possible, GP's who had completed a questionnaire),
- one senior educationalist per site.

In addition, efforts were made to interview as many midwives as possible at each site. Midwives were written to in advance, and posters were displayed at each site indicating the times the research team would be available, and the interview location. Times were given for both individual interviews and focus groups, so that midwives could choose whether to attend individually or in groups.

When the research team were visiting the study sites personal contact was made with midwives by the researchers visiting the wards, clinics and delivery suite on a regular basis (throughout all shifts).

Most midwives were seen in a group (of between 4-8) but a small number were seen individually (mostly as they could not come in at a time when a group was being held). A total of 90 midwives were seen.

2.1.3 Interview methods and topics

The primary purpose of the case studies was to inform the development of the educational package. Semi-structured topic guides were prepared which allowed significant issues raised through the questionnaire data to be followed up with the various groups.

Focus groups were held with midwives, mainly in order that as many staff as possible could be interviewed. Also, a richness of debate may be facilitated through group discussion. However, there may also be disadvantages of focus groups. For example, individuals may not feel free, for various reasons to express their true feelings and views. For this reason, individual interviews were also offered to midwives. The relative advantages and disadvantages of focus groups have been well documented(see 211), and the significance of methodological issues must always be borne in mind when results are being interpreted.

A wide range of issues covered under each of the key section headings in the questionnaires were followed up in the interviews.

Specifically, midwives and supervisors were asked about the continuing education/training needs of midwives, including:

- *current educational/training provision (particularly in relation to issues identified through the questionnaires),*
- *areas of outstanding educational/training need,*
- *most appropriate ways of meeting outstanding need,*
- *familiarity and preference for various educational methods,*

- *range of issues related to the most appropriate delivery of an educational package at local level, including the type of support that would be required by students, and ways of helping students to become motivated for further study,*

- *potential content and presentation of educational package; potential academic level of package (including opportunities for Credit Accumulation Transfer Scheme, Accreditation of Prior Learning etc.),*

- *how package might fit in with PREP/ENB Higher Award,*

- *which groups of professionals/academics should develop/write package,*

- *how much time respondents might spend working on package,*

- *whether unit would support potential students in terms of finance/time off work.*

In addition to interview data, relevant documentation regarding the planning and delivery of the maternity service was collected from each case study site (e.g. operational and business plans, strategic plans, public health reports, procedures, policies and standards for service delivery). Documentary analysis was undertaken to further an understanding of the information obtained through the interviews.

Interviews lasted between one and two hours, depending on how much discussion the participants wished to have. Generally, the groups with midwives tended to last longer (due to the debate that arose) than individual interviews.

2.2 Consumers

2.2.1 Background to development of the method

The data for this study were collected primarily from health professionals, but it was also considered important that contemporaneous data from consumers were available to illuminate the other study findings, particularly in relation to informing the development of the educational package. Due to the tight project timescale the scope for collecting data for this aspect of the study was necessarily limited. However, within this context a number of potential methods for obtaining information from consumers were considered. Numerous studies of consumer satisfaction regarding the maternity service have been reported in the literature, and it has to borne in mind that there are many potential methodological problems related to studying this area. (see 28 for overview of some relevant issues). An overview of the method that was selected for this study has been outlined below.

Various methods were considered regarding data collection. It was eventually decided that a fairly structured research tool would be designed for use with mothers (of babies up to the age of 3 months) through individual interview with a researcher in Child Health Clinics.

It was decided to seek permission for the sample to be obtained by visiting Child Health Clinics (clinics) in the case study sites. This would allow for contemporaneous data to be available from a wide range of health professionals and mothers from the same area, thereby providing a broader context for the understanding of the study findings.

This method was viewed as having several advantages over a postal questionnaire, which was also considered following discussions in the Steering Committee. The timescale, for this aspect of the study was very tight, and preliminary enquiries indicated that it would take a prohibitive amount of time to obtain the names and addresses of consumers from local health authorities/trusts. Further concerns related to the possibility of a low/'skewed' response. For example, those who have difficulties reading English, or who are in difficult personal circumstances may find a postal questionnaire difficult to complete. Also, a postal method would not allow for any sample screening (without other complex procedures being undertaken) to ensure that women who experienced specific obstetric or medical problems were not included in the sample. It was considered advisable not to include such women for ethical and methodological reasons (see below for further discussion) .

The method of obtaining the sample through clinics was also considered to be preferable to visiting groups attended by women with young babies, (e.g. National Childbirth Trust/other postnatal groups), as women from a broader range of backgrounds tend to attend clinics. Local data available for the case study sites indicated high attendance rates at clinics in the early months following birth.

2.2.2 The sample

It was proposed that the **total** sample size would be approximately 100 mothers, with babies up to the age of 3 months. It was be important to gain access to mothers who reflected the background of women who lived in the locality. Therefore, the actual number of clinics visited in each site was determined by attendance rates and the background of mothers attending particular clinics. (Eventually, data were only collected in 2 of the 3 case study sites for reasons outlined below, but the total sample size remained as originally planned).

Mothers with babies up to the age of 3 months were chosen for inclusion in the study as they would have had recent contact with the professionals providing maternity care throughout the antenatal, intrapartum and postnatal periods. The results obtained from these mothers would therefore be likely to provide information from a broad perspective that would be useful in developing the educational package for midwives. However, it is important to acknowledge that within the framework of this study, it was not possible to take account of the important views of other maternity service users such as fathers, nor to have an in-depth understanding of how mothers actually felt when they were experiencing antenatal and intrapartum care. Views expressed in retrospect may, of course, differ from those given at the time an event/s is/are being experienced.

The literature indicates that many factors are likely to have an effect on consumer satisfaction with the maternity service, e.g. age, ethnic background, occupational status, obstetric history, medical history. Within the remit of this study it was not possible to systematically take account of all these variables.

It was decided therefore, not to include women who had obstetric/medical complications during the antenatal, intrapartum or postnatal periods (complications as defined at local level). This would prevent the findings from being affected by widely different experiences on behalf of the mothers and it would avoid women with difficult histories being asked about their experiences. If women with difficult histories were going to be included in the study, precautions would have had to have been taken to ensure that women were not being asked to discuss potentially distressing issues, and then left without an adequate source of support. The inclusion of women without complications was also beneficial in this study, in so far as such women were more likely to receive a substantial amount of care from midwives (who were the main focus of the questions for this part of the work).

Obviously, it is important to recognise these findings do not represent the views of **all** women, but in the event, all the women who attended the clinics when the researchers were collecting data were eligible for inclusion in the study, apart from one woman who knew from early on in the pregnancy that her baby had a particular disability. The sample included:

- first time mothers, and those with other children,
- mothers from all social classes (registrar general classification).

Five clinics were visited in site 1 and six clinics were visited in site 2.

2.2.3 Development of the research tool

Questions were written that focused on the views of mothers regarding the service received from **midwives**. Such information provides a useful context for the understanding of data from other parts of the study, and the development of the educational package.

Questions were written on the basis of the literature, current policy and practice trends, and expert advice obtained from Steering Committee members. (The type of questions that have not proved successful in past studies were avoided, e.g. a lot of questions about general satisfaction with the service which tend not to discriminate effectively). No other research tool was available for use in the study, but where appropriate questions were adapted for use from the OPCS manual on Women's Experiences of Maternity Care(213). Questions were piloted with relevant samples of mothers before use.

The questions took about 15-20 minutes to answer verbally, depending on the amount of detail mothers wished to give. In addition, women were provided with the opportunity to comment on issues important to them. Interviews took place in clinics, but a private place was arranged for discussion between the researcher and the mother. Questions focused around:

- details about the baby,
- information about the pregnancy (including service provision and opportunities for discussing maternal choice,
- information about the postnatal period (including provision of care from the midwifery service),
- information regarding the helpfulness/unhelpfulness of midwives throughout the period of care. Mothers were also asked what they considered makes a good midwife,
- details about the mother.

2.2.4 Ethical issues

Local Ethical Committee approval was necessary before data were collected. Due to the way in which data were collected, it was considered important not to include mothers who may have found it potentially distressing to discuss their experiences - such as those who had a baby with disabilities/severe health problems. Data were collected in a clinic environment, in short space of time and there was not the facility for the researchers to provide any follow up visits to mothers, or to build up a relationship with them prior to collecting the data.

Therefore, it was decided that it would be most appropriate for health visitors in the clinics to assist in the selection of the sample by indicating to the researchers which mothers were suitable for inclusion in the study before they were approached. Ethical approval was given under these conditions in 2 of the three case study sites (subject to the usual procedures for ensuring the mothers interests were observed).

In the third site, the ethical committee procedures took considerably longer than in the other 2 sites. It eventually became impossible to collect data from this site within the framework of this study. Therefore, it was decided to include extra mothers in the other 2 sites in order that the total number of mothers in the study remained as originally planned.

2.3 Interviews with National Organisations Involved in the Development of the Maternity Service

In addition to obtaining information from health professionals/managers and mothers, it was considered that it would be important to interview representatives from national bodies involved in the development of educational policy and initiatives for professionals working within the maternity service.

To this end, appointments were arranged to interview relevant representatives at the Department of Health, Royal College of Midwives, Royal College of General Practitioners, Royal College of Obstetricians and Gynaecologists, United Kingdom Central Council for Nursing, Midwifery and Health Visiting, and the English National Board for Nursing, Midwifery and Health Visiting. Interviews were undertaken using a semi-structured format and focused around:

- the views of the organisations regarding the current role and responsibilities of the various professionals involved in the delivery of the maternity service, and the potential for future developments;

- the role and views of the organisations regarding the development of educational policy for professional groups, and the factors that affect the types of educational initiatives that are developed.

This information was used to inform the development of the package.

In summary, the information obtained from the questionnaires and case studies allowed for a broad picture to be built up of the role and responsibilities of midwives from the perspective of those who have key responsibility for maternity service provision. In the light of the remit of the study to provide a broad research base for the development of an educational package for midwives, it was not considered that it would be appropriate for information to be obtained from alternative sources to further validate the findings from the questionnaires and case studies. For example, observational data is often useful in providing an 'objective' perspective in relation to the practice of health professionals, but this method is most suitable for obtaining detailed data in relation to a clearly defined area of practice. It would not have provided the breadth of information required for a study of this nature.

It is important to note that those who participate in research studies may be different from those who choose not to take part. On this occasion, the generally high response rates, particularly from supervisors and midwives allow considerable confidence in the representativeness of the findings, but there was a small percentage of both groups whose views have not been represented in this study (see Chapters 3-7 for information on response rates). In particular, it needs to be noted that the response rate obtained from the registrars was below 50%. Questionnaires were sent out in August when registrars traditionally change jobs. A number of registrars indicated that they did not feel sufficiently knowledgeable about the unit they had recently joined to comment.

3. AIM 3:

TO DEVELOP AN EDUCATIONAL PACKAGE TO FACILITATE MIDWIVES IN RESPONDING TO THE REQUIREMENTS OF THEIR CHANGING ROLE AND RESPONSIBILITIES (12 months)

This section focuses on:

- background to package development,
- planning and management strategies for package development,
- development of the philosophy underpinning package,
- development of the package.

3.1 Background to Package

The research findings from the first two phases of the study were used to inform the development of the educational package. In addition, the available literature was drawn on when work was being planned. The expertise of members on the Curriculum Advisory Group and Curriculum Development Group was also used to inform package development (see below and the Appendix).

3.2 Planning and Management Strategies for Educational Package

The questions used for the research (questionnaires and interviews) were planned to provide relevant information for the development of the package via several sources (e.g. perceptions of the competence/confidence of midwives to undertake their full role; factors affecting midwives capacity to work within a variety of settings and to undertake their full role; continuing educational need and appropriate means of meeting outstanding need. See Sections 1 and 2 above).

A Curriculum Advisory Group was set up, to inform the strategic direction of the package, and a Curriculum Development Group was set up to work specifically on the development of the curriculum. The groups were responsible to the project director who reported to the project Steering Committee on a regular basis.

The membership of the groups was designed to ensure that expertise from a wide range of areas related to the delivery of the maternity service, and the development of educational packages was available. Consequently, members were drawn from:

- the midwifery profession (midwives engaged in clinical work, supervision, management, education, research, policy making and professional development),
- obstetrics,
- general practice,
- education (including curriculum design and accreditation expertise),
- relevant academic disciplines, e.g. anthropology, sociology, psychology (members were authors of articles and texts on relevant issues),
- editorial services,
- a consumer group.

A project schedule was devised based on the time allocated to develop the package (one year), the resources available, and the type of the package likely to be most acceptable to professionals. (The research findings informed this process). When these factors were taken into account, it seemed appropriate to plan towards the development of a written package of approximately 60,000 words (illustrative material, offprints etc. to be used as appropriate).

Within the budget available, it was not possible to consider supplementing the written material with other learning methods (e.g. video tapes, computer assisted techniques etc.). However, such methods were not requested when the research regarding the educational package was being undertaken.

In addition to planning the writing of the package, time was allocated for the crucial processes of involving expert critical readers and midwife testers (midwives for whom the package was being developed). Midwife testers were drawn from the case study sites where midwives had provided information on package development and from a small number of units where case studies had not been undertaken. Further information regarding the readers and testers is outlined in the Appendix.

3.3 Development of Philosophy Underpinning the Package

It is important that the package is flexible enough to meet the needs of midwives from varying backgrounds working in a diversity of situations, and, as outlined in the project specification, it needs to fit in with the ENB's Higher Award framework and the proposals outlined in PREP. Current policy trends also need to be addressed (e.g. Changing Childbirth).

In addition, the package needs be accepted by managers as an appropriate means of providing continuing education, in order that they will support its use in practice. This will only happen if the package is seen to be a cost-effective and efficient way of assisting midwives in developing or enhancing the skills required at local level. The research findings were used to determine the most effective way of eliciting the support of as many managers as possible. However, the priority was to ensure that the midwives who will be using the package consider that their needs are met within a stimulating and supportive framework.

Clearly, there will be a context in which continuing professional education will take place. This will be affected by national and local agendas, and the workplace environment. Within this context (and in the light of the information obtained through the research) the need was identified to:

(i) focus on the professional's access to educational material and

(ii) on the way that access to relevant material is facilitated.

It will be important for professionals to:

- *be at the centre of the learning process,*
- *be in control of the learning process (e.g. focus and pace of studies),*
- *have access to appropriate materials; be aware of other materials that may be of relevance, and be stimulated by the material,*
- *be free to learn in a context of support, reciprocity and respect; which will foster self-esteem and a sense of personal and professional growth,*
- *be encouraged to build on their experience and feel safe to explore further, and take risks.*

An 'open' learning philosophy was therefore used to underpin package development as it facilitates the choice and control of learners over their own development. It is acknowledged that 'open learning' is not a definitive term but rather that it describes a range of strategies within which the depth, breadth, amount and mode of study that will be undertaken by an individual may be determined. The use of this approach has introduced a flexibility for learners that has been facilitated through the indicative content and assessment of the package. This approach is consistent with the postulation of Clark and Robinson(1994) that *"it is the control over the essential elements of the curriculum in terms of the content and assessment which shift the locus of control substantially away from the teacher towards the learner"*(54:259).

It may also be useful, at this stage, to bear in mind the position outlined by Davis(1993): *"openness and closure are two ends of a pathway from complete closure to complete openness. A course may be developed within an educational philosophy at any point between the two extremes"* (62:6).

In line with the philosophy discussed above, emphasis has been placed on the value of promoting enquiry based learning through reflection and critical analysis (see Boyd and Fales 1983(49), Boud et al 1985(50)). Major pieces of work will encourage in-depth enquiry through reading, and the critical appraisal of research studies.

3.4 Content and Presentation of Package

An overview of the contents of the package has been included in the Appendix. The basis for the contents, and the way in which the package has been presented have been informed by the research findings which are further discussed in the results chapters. In addition, an overview of the way the research was used to inform package development has been included in the learning resources book that has been prepared to accompany the package.

3.5 Academic/Professional Level of Package and Support Networks

The research findings indicated the need to pay careful attention to the levels at which the various sections of the package were designed. Some midwives clearly require their education to lead to academic credit. However, there will also be midwives who will wish to access the package (at least initially), without wishing to acquire credit. Another possibility is that, in the light of PREP, the package may be used in relation to professional updating.

Due to the complexities surrounding potential use of the package by midwives, a learning handbook has been developed to go alongside the package. The importance of identifying appropriate support networks at local level to facilitate use of the package has been addressed in the handbook. Educationalists who may wish to use the package for validation purposes or for other work linked to their educational institution will find that guidance has been included in the handbook.

4. ANALYSIS STRATEGY

The data were analysed in several stages. The framework used has been outlined below.

4.1 Supervisors (questionnaire data)

Basic information was obtained for every question asked in order to build up:

(i) a general picture of the sample,

(ii) an overview of the service provided at local level.

4.2 Midwives - NHS sample (questionnaire data)

- Basic information was obtained for every question asked in order to build up a general picture of the sample, and most importantly to provide information about midwives across England that could be used to inform the development of an educational package.

- On the basis of the literature outlined in Chapter 1, and the need to obtain the information required to develop an educational package that meets the needs of midwives from a broad range of backgrounds, analyses were undertaken to look at key factors that may affect midwives practice:

    - midwives grade,

    - practice base of midwives (community, hospital or 'integrated', i.e., working in both community and hospital settings),

    - full or part-time working.

Although it was not directly relevant to the information required to develop the educational package, responses were also analysed by whether midwives worked in a small, medium or large unit. This was done as the literature indicates that in the light of recent changes towards locally based provider units, there may be potential differences in relation to the size of the unit, regarding the potential for service provision(e.g.97,105). Analysis of the midwives responses by size of unit was therefore considered useful to shed further light on such issues.

- Initial analyses were undertaken to ascertain whether there were any differences between the sample of midwives who had been selected:

  (a) through units where midwives had been sent questionnaires directly

  (b) through units where questionnaires had been distributed to midwives by their supervisors on the basis of an identification number (see methods for further discussion regarding this issue).

There were not any significant differences, therefore, the midwives were all included in the same sample for analyses purposes.

4.2.1 Independent midwives (questionnaire data)

- Basic information was obtained for every question asked in order to build up a general picture of the sample.

Comparative analyses were undertaken between the independent midwives and the NHS sample of midwives.

4.3 Comparative Analyses Between Professional Groups (questionnaire data)

- Some comparative analyses were undertaken between the responses obtained from all the professional groups studied: supervisors, NHS midwives, hospital doctors and GP's). This was possible where similar questions had been asked of all the different groups.

- Some questions were asked of the midwives and supervisors only. Under these circumstances analyses were undertaken between the 2 groups.

- Information was obtained regarding the extent to which there was agreement between staff working within the same unit:

  (a) the extent to which midwives agreed with each other

  (b) the extent to which the midwives and the supervisor agreed

  (c) the extent to which the supervisor and the consultant agreed

- Midwives were drawn from a subsample of maternity units in England (60 units, from a total of 205 in England). Supervisors were drawn from all units in England (205 - 33 did not respond). In order to check for differences between the 60 units from which midwives were sampled, and the rest of the units across the country, a comparison was made between the responses of the supervisors from the 60 units and those from the units where midwives were not included in the sample. No significant differences between these two subsamples were found. Therefore, analyses were subsequently undertaken using the responses obtained from all the midwives and supervisors sampled.

4.4 Case Studies with Professionals

The information obtained has been analysed using content analysis.

4.5 Mothers

- Basic information was obtained for every question in order to build up a general picture of the sample.
- On the basis of the literature, analyses were undertaken by:
    - social class
    - educational attainment
    - parity (primipara or multipara)
    - whether the mother was cared for by one or more midwife/s.

Analyses were also undertaken to determine whether there were any differences between mothers responses between the 2 case study sites used for data collection.

4.6 Statistical Analyses and Reporting of Findings

Statistical tests were undertaken as appropriate. The Chi squared test, t-test, one way analysis of variance, and correlations were used as appropriate.

It is important to recognise that the greater the number of statistical tests carried out on one data set, the higher the overall risk of a 'false-positive' result. Highly significant findings (for example, $p<0.001$) are more likely to be viewed with confidence in this context, and reducing the level of statistical significance from the conventional 5% level may therefore be beneficial(e.g. see 118). However, it is also important to acknowledge that the level of statistical significance reached is not the only criterion for interpreting how important findings may be. Bland has pointed out that although a difference is statistically significant, it may not necessarily be important(119). On the other hand, even though a difference may not be highly statistically significant it may be important in terms of its potential meaning to practice and policy issues.

Many of the results that have been reported throughout this report are highly statistically significant($p<0.00001$). However, in order to maximise the potential for findings to be used in the most informative way, statistically significant results have been reported for all levels (5% and below), if the findings appear to be of practical importance in the context of the other study findings.

Confidence intervals were obtained where appropriate but due to the large amount of information presented in each chapter they have not been systematically reported. This information has been retained by the project team and will be made available when papers are submitted for publication on specific aspects of the work, or by request to the project director.

4.6.1 Analysis of Open-Ended Questions

Open-ended questions were asked throughout the questionnaire to further understanding in relation to the data obtained through the closed questions for which numerical data has been reported throughout the results chapters. Content analysis was undertaken for the open-ended questions, and the results have been presented in summary form.

4.6.2 Reporting Procedure

The results from the questionnaire phase of the study with the professionals have been reported in Chapters 3-5. The results from the professionals from the 3 case study sites, and the interviews with representatives of national organisations involved in the development of the maternity services have been reported in Chapter 6. The results from the mothers from the two case study sites where data were collected have been reported in Chapter 7.

As has been discussed earlier, the questionnaires for each of the professional groups were kept as similar as possible for comparative purposes. However, both supervisors and midwives were asked some questions that the other groups were not asked in order that important issues could be further investigated.

In order to present the findings as clearly as possible, and to minimise repetition, results from questions that were asked of all the professional groups have been reported in Chapter 5. However, it has also been necessary to present much of the midwife data separately as analyses were undertaken by grade, practice base and full/part-time working. Basic descriptive data have been reported largely by graphical representation. Sub-analyses, have largely been reported in a text based format. This style has been adopted to enhance clarity and ease of understanding as much as possible, in the light of the large amount of potentially complex data reported.

In addition, a small number of questions were only asked of the supervisors. Responses to those questions have been reported in a separate chapter.

It has only been necessary, in the main, to report the *statistical data* for the midwives separately. On many occasions, open-ended questions were asked to obtain further information about a particular question. When these questions were asked of all the professionals, the midwives responses have been drawn together with the data from the other groups, in Chapter 5.

As the results presented in Chapters 3-7 cover similar issues from a variety of perspectives, the strategy of simply reporting the findings has been adopted, and the substantive drawing together and discussion of the findings from all the chapters has been undertaken in Chapter 8.

The results chapters have been written with a professional audience in mind. The intention has been to present the findings in a way that midwives and managers find the information as useful and accessible as possible.

The chapters reporting the findings from the professionals have been organised in the following way:

Section (i)	background information about the sample (except for the comparative chapter)
Section (ii)	information regarding service provision at local level
Section (iii)	information regarding the role and responsibilities of midwives.

In order to show exactly what questions were asked, and make the data as easy to read as possible, each question has been presented, followed by the appropriate response.

5. FRAMEWORK FOR STUDY AND DEFINITION OF TERMS

The issues addressed in the questionnaire, and the rationale for the content have been discussed above. In this section the way that terms have been used in the various sections of the questionnaire have been defined. In some questions the respondents were not provided with a definition of terminology by the researchers in order that an understanding of the way/s in which terms were being used by professionals could be obtained, for the purpose of informing practice. Unless a definition of the way in which terms were used has been outlined below it should be assumed that respondents were not provided with a definition by the researchers. The ways in which the terms were used by respondents have been reported in the results chapters.

5.1 Framework for Study

In the light of the broad remit of midwives, and the emphasis placed on the provision of woman-centred care, acknowledging that every woman has unique needs, it was considered appropriate to adopt a framework for study that would allow the potential breadth of the role to be investigated(9,47,5). Therefore, the concept of 'individualised care' was chosen to underpin the framework for data collection. Individualised care is based on the assumption that high quality care depends on the recognition of individuals as having unique needs. The importance of addressing social and emotional, as well as biological and physiological needs is stressed. The aim is to provide a supportive relationship within which care is provided(78,117). Questions were therefore written to reflect the role and responsibilities of midwives within this broad framework.

5.2 Definition of Terms in Relation to the Provision of the Maternity Service

5.2.1 Systems of care

For the purposes of this study, 'systems' of care is being used as an umbrella term to cover ways in which midwifery (and sometimes broader aspects of maternity care) is provided. This may refer to the place of birth of birth (e.g. home birth), or the professionals who are involved in providing care (e.g. shared care, midwife only beds), or the organisation of care between the midwives in the unit (e.g. teams, caseload management, named midwife), or a scheme (e.g. domino). Some of these systems may operate in conjunction with other (e.g. domino care or home births might be provided by midwives working within a team or carrying a caseload care, and the named midwife might operate within a team arrangement etc.).

It was not possible to understand the complexities around systems of care before this study was carried out. Therefore, the questions that were asked allowed for an analysis of the situation to be undertaken, not only in relation to the systems that were in operation, but also to further an understanding of the way in which certain systems operated in conjunction with each other.

The terms related to systems of care were not defined for the respondents.

5.2.2 Changing Childbirth

Several questions related to the implementation of the recommendations of Changing Childbirth. Respondents were informed that the questions related to the Changing Childbirth Report(1993), HMSO. The 'lead professional' was also defined for respondents as outlined in the report, but no other definitions were given of the terms used in the report.

5.2.3 'Integrated' midwife

Wraight et al(3), used the term 'integrated' midwife to describe a midwife who worked in both hospital and community settings. This term has been used for brevity in this report and a full explanation of the different ways in which 'integrated' midwives worked has been discussed in the results chapters. However, the term was **not** used in the questionnaire. Midwives were asked to indicate whether they worked in hospital only, community only, or both hospital and community settings.

5.3 Role and Responsibilities of Midwives

The activities of a midwife were included in one of the questions. The respondents were provided with the following information: *"On the following page, some of the issues relate to the UKCC Midwives Code of Practice 1994/European Community Midwives Directive 80/155/EEC. Additional issues have been included in order to get a more complete picture of the role and responsibilities of midwives"*. It was not indicated which questions specifically related to the above Directive.

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CHAPTER 3: SUPERVISOR RESULTS (Questionnaire)

Results have been presented in 3 sections:

SECTION 1 BACKGROUND INFORMATION

SECTION 2 NEEDS OF THE LOCAL POPULATION

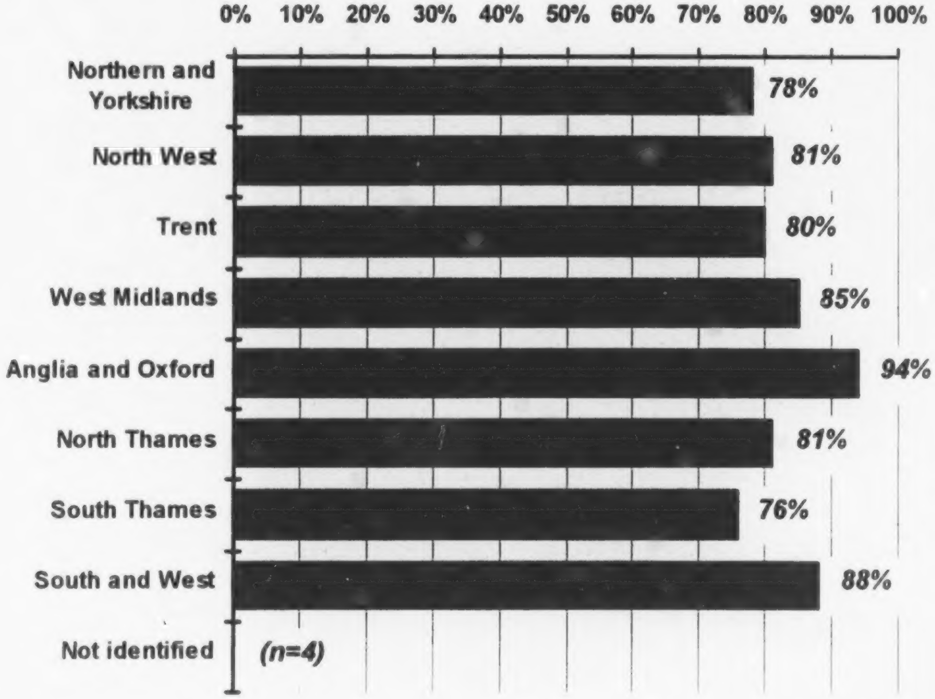
SECTION 3 CONTINUING EDUCATION

SECTION 1 BACKGROUND INFORMATION

Questionnaires were distributed to 205 supervisors. One hundred and seventy two supervisors returned a completed questionnaire, a response rate of 83%.

1.1 NHS Region: Response Rates of Supervisors by Region

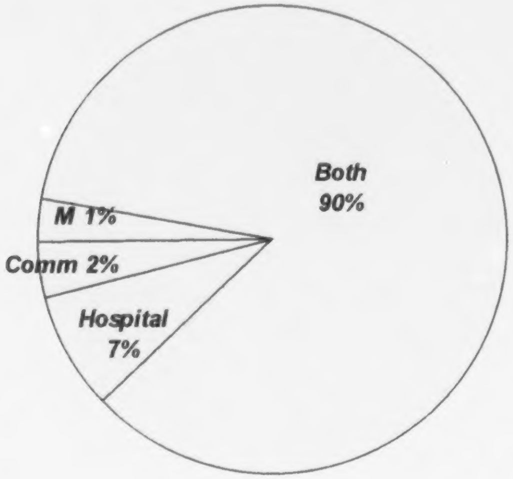
Figure 3.1: Response rate by region (n=172)



1.2 Background of the Supervisors

Supervisors were asked to indicate whether they had responsibility for community services only, hospital services only or both hospital and community services.

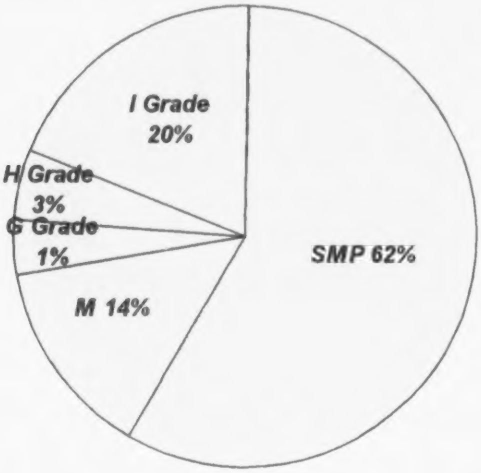
Figure 3.2: Responsibility for service provision (n=172)



[1]

Supervisors were asked what their current grade/status was.

Figure 3.3: Supervisor's grade structure (n = 172) *SMP = Senior Management Payscale*



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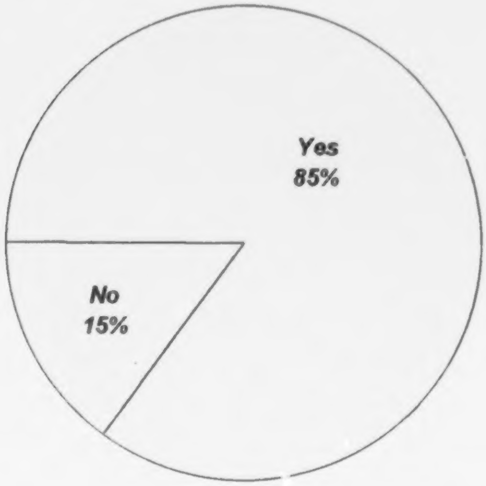
[1] *Throughout the pie charts DK = don't know, M = missing*

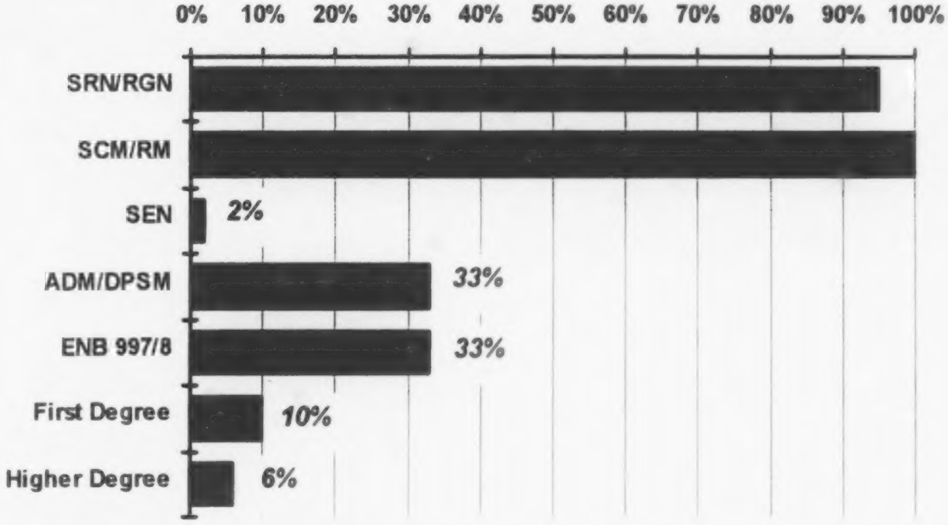
Supervisors were asked to indicate whether they were the Head of Midwifery in their service.

Figure 3.4: Head of midwifery service (n=172)



Supervisors were asked to indicate whether they held the following qualifications.

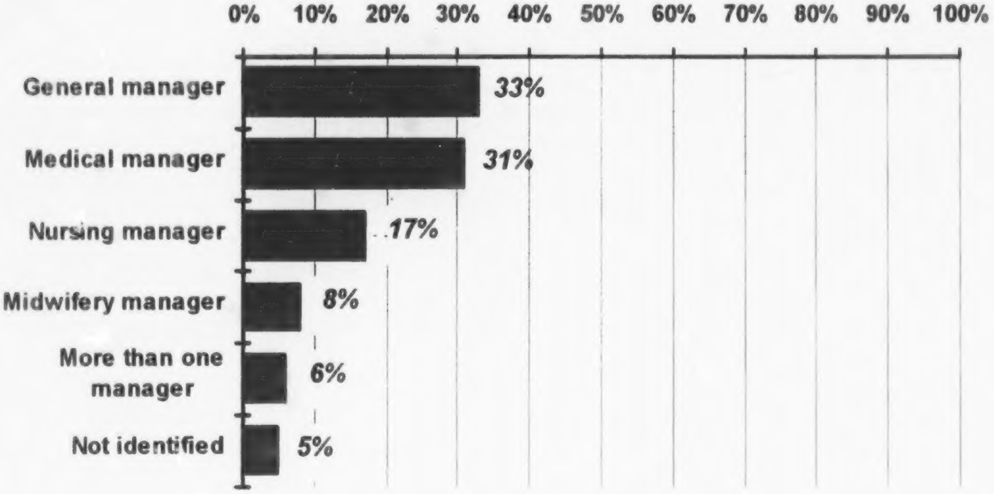
Figure 3.5 Qualifications of supervisors (n=172)



Other relevant qualifications included: a management diploma or certificate (27%), other nursing qualifications (6%), a teacher or tutor certificate (4%) and 1% indicated that they had completed a supervisor of midwives course.

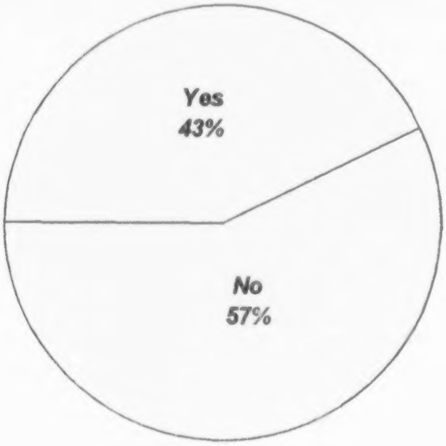
Supervisors were asked to indicate who was their line manager.

Figure 3.6: Supervisor's line manager (n=172)



Supervisors were asked to indicate whether they personally provided care for women, and to explain how this occurred.

Figure 3.7: Supervisor's involvement in care provision (n=172)



Less than half of the supervisors personally provided care to women in their service. Of those who did provide care, just under half indicated that it was only when the unit was busy, when they were on call, or that it was on an ad-hoc basis. Less than a quarter provided care in all service areas, and a very small number provided water births or home births. A small number indicated that they had their own caseload and 8 indicated that the only direct contact they had with consumers related to dealing with complaints.

Supervisors were asked to indicate on a 5 point scale how much control they considered they had to make decisions regarding their work. (1= no control; 5 = total control). Supervisors were asked to explain their answer.

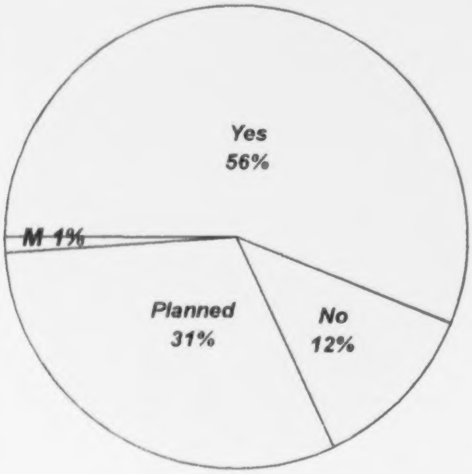
Table 3.1: Supervisor's degree of control re: decision making (n=172)

Decision Making	%
5 - Total Control	14
4	63
3	16
2	5
1 - No Control	1
Missing	1
Total	100

Nearly 90% of supervisors commented. Just under half reported that they made decisions in conjunction with the clinical director, business manager or chief executive. Just under half commented that they felt they had control, or a reasonable amount of autonomy regarding professional midwifery decisions. However, joint decisions were made about broader service matters, such as budgeting. A small number considered that local policies, local purchasers and government directives limited the amount of control they had.

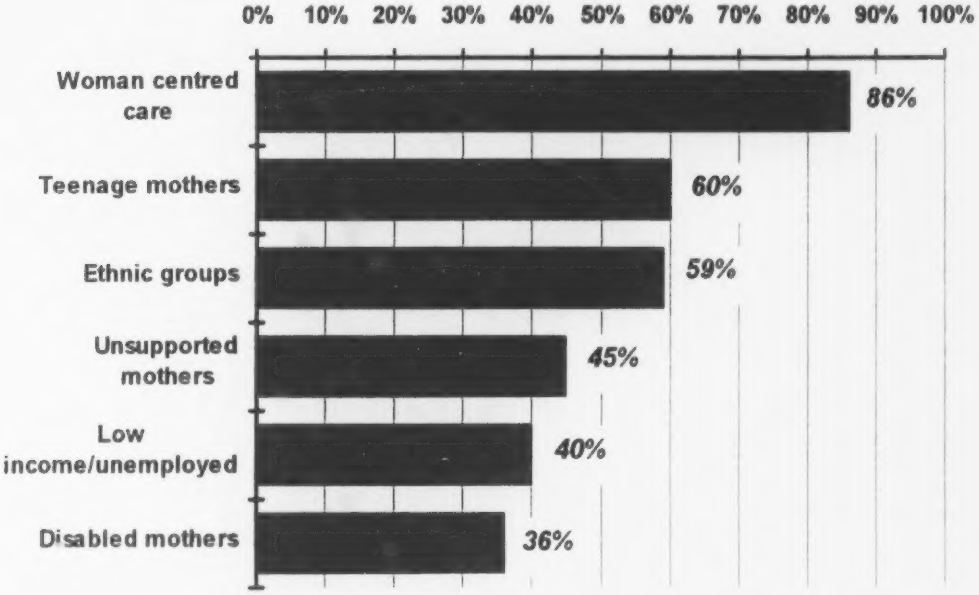
Supervisors were asked to indicate whether there was a strategic plan or formal policy for delivery of the maternity services.

Figure 3.8: Strategic plan in place for service delivery (n=172)



Supervisors who answered yes were asked to indicate whether any of the following areas/population groups were included, and to provide brief details:

Figure 3.9: Areas/groups included within strategic plan (n=97)

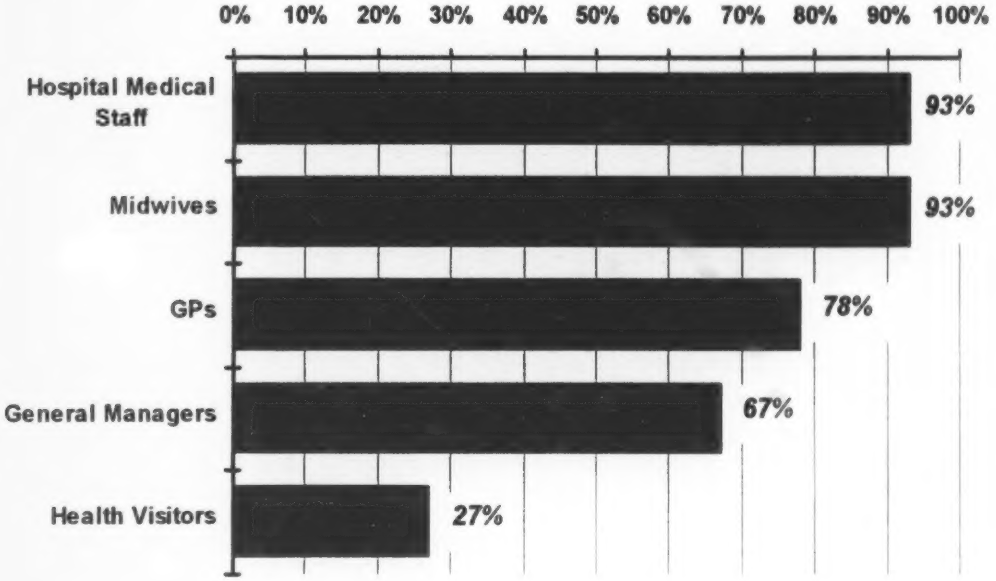


Other (6%)

Over half the supervisors commented. Of those who commented, the majority indicated the importance of including women from a range of ethnic backgrounds in the strategy. A small number indicated the importance of teenage mothers, or disabled mothers being included in the strategy. Other groups mentioned by a minority included the homeless, those on a low income, alcohol dependent women, infertile couples, families with children at risk, the unemployed and diabetic women.

Supervisors who indicated a strategic plan/policy had been implemented were asked whether any of the following were consulted in the process of determining policy/strategy for maternity service.

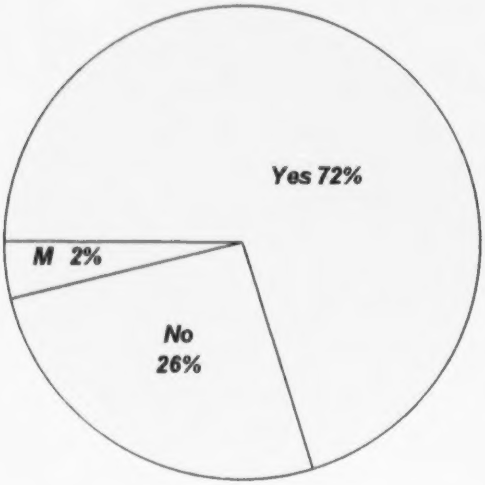
Figure 3.10: Professions consulted for strategic plan (n=97)



Others included consumer organisations (12%) and purchasers (11%). A small number reported the involvement of politicians and finance departments.

Supervisors were asked whether targets/goals were outlined for attainment by the maternity services.

Figure 3.11: Targets/goals outlined for service (n=172)



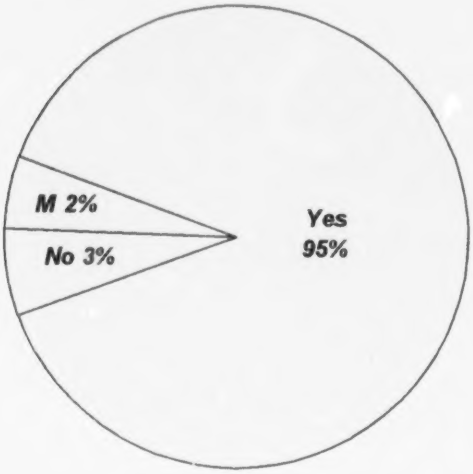
Supervisors were asked to provide details concerning the targets/goals outlined for attainment in their service.

Approximately three quarters of supervisors commented. Of those who commented, approximately a quarter indicated that targets were set in the business plan in line with the annual objectives. Just under a quarter indicated that targets related to Changing Childbirth had been set in order to provide woman-centred care.

A small number indicated that targets were determined in conjunction with purchasers, or through an audit or quality control procedure, or were in line with the Patients Charter and/or the Health of the Nation document. A small number of supervisors mentioned specific targets, such as improving breast feeding rates, decreasing clinic waiting times, reducing smoking in pregnancy, increasing the domino service and team midwifery, reducing infant mortality rates, teenage pregnancies and the number of low birth weight babies.

Supervisors were asked whether services were regularly monitored to take account of the needs and requirements of consumers, and how this occurred.

Figure 3.12: Monitoring consumer needs and requirements (n=172)

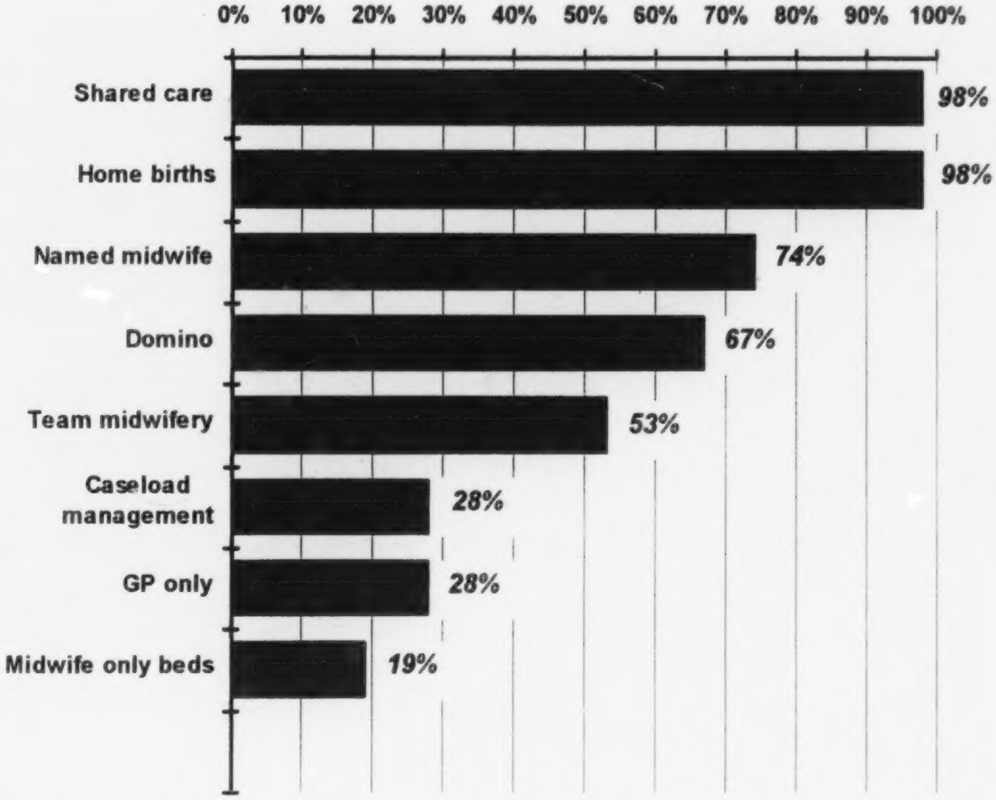


Comments were made by over 90% of the sample. Over half of the comments indicated that feedback was obtained from questionnaires. Approximately a quarter obtained information from the National Childbirth Trust, or other postnatal support groups, or from Maternity Service Liaison Committees. Just under a quarter indicated that the Community Health Council gave feedback, and was involved whenever an official complaint was made by a service user.

A small number indicated that complaints made formally or informally were a useful means of feedback. A small number of other methods were mentioned, for example, feedback from bereavement groups, the use of the OPCS survey and a suggestion box. A very small number employed an independent company to carry out a consumer satisfaction survey.

Supervisors were asked to indicate which of the following systems of care are currently available.

Figure 3.13: Systems of care (n=172)



Other n=7

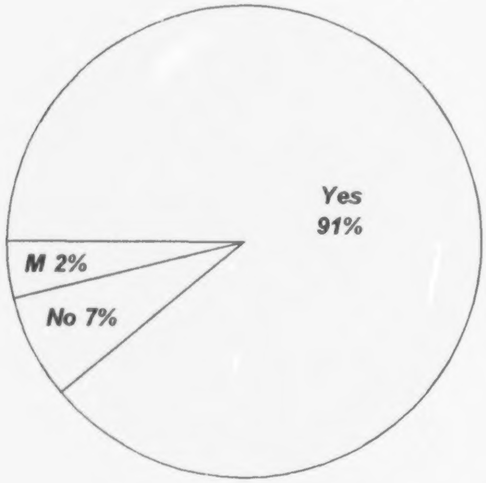
82

SECTION 3 CONTINUING EDUCATION

3.1 Supervisors Continuing Education Needs

Supervisors were asked to indicate whether[*] they personally required continuing education/training, and in what areas.

Figure 3.14: Supervisors requiring further education (n=172)



Approximately forty percent of supervisors identified management issues as a further education need. Emphasis was largely placed on business planning, financial contracting, time management and marketing. Approximately a quarter identified clinical and counselling skills, in particular IV cannulation, water births, neonatal care, perineal suturing and care in relation to HIV/AIDS. Research was identified by approximately a quarter, and a small number identified quality assurance and audit. Supervision issues were identified by a small number, as was further education in relation to the changing health service at both local and national level. The availability of study days for supervisors was generally considered to be limited and not always appropriate to supervisors needs. Other areas identified by small numbers included ethico-legal issues and information technology.

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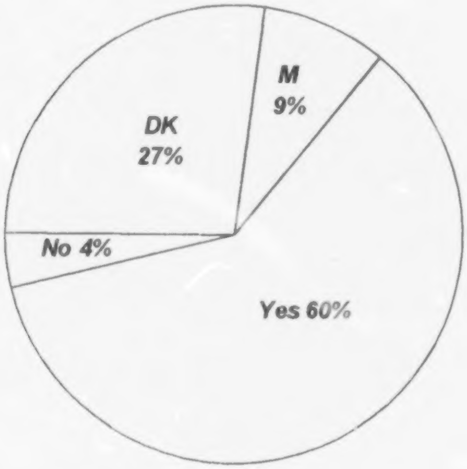
[*] *The terms education and training have been used throughout Chapters 3 and 4 to refer to all continuing programmes of study.*

3.2 Support for Open Learning Package

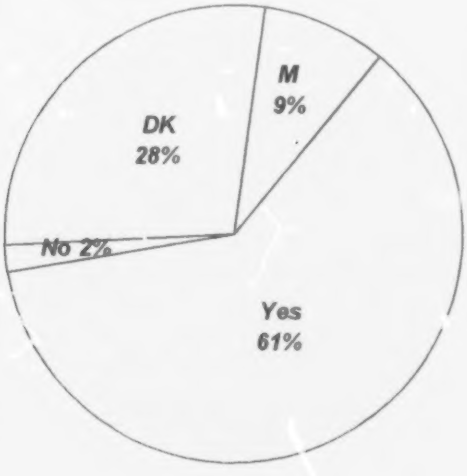
Supervisors were asked whether clinical facilitator support would be available in their unit to support midwives if an open learning package were to be developed.

Figure 3.15: Clinical facilitation for package (n=172)



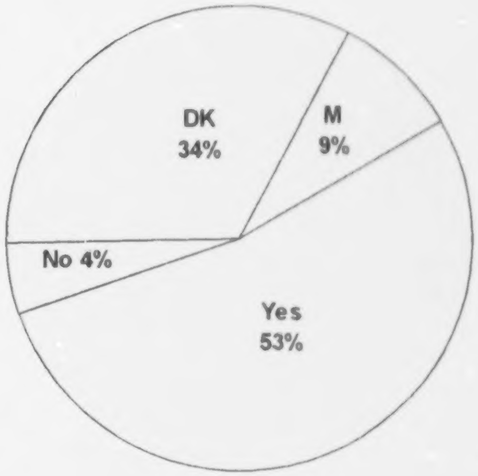
Supervisors were asked whether they would be able to negotiate support from local midwifery educators to facilitate open learning for staff.

Figure 3.16: Local educational support for package (n=172)



Supervisors were asked whether their service would be prepared to pay for open learning materials and facilitator support, if they considered the package would adequately address the continuing educational needs of their staff.

Figure 3.17: Financial support for package (n=172)



The picture regarding support at local level for those using open learning was quite positive, but obviously there was some uncertainty about what exactly could be offered to individual midwives in this respect.

CHAPTER 4: MIDWIFE RESULTS (Questionnaire)

Results have been presented in 7 sections.

SECTION 1 RESPONSE RATES AND BACKGROUND OF NHS MIDWIVES

SECTION 2 PROVISION OF MATERNITY SERVICES

SECTION 3 ROLE AND RESPONSIBILITIES OF NHS MIDWIVES

SECTION 4 EDUCATION AND TRAINING NEEDS OF NHS MIDWIVES

SECTION 5 H AND I GRADE MIDWIVES

SECTION 6 ANALYSES BY SIZE OF UNIT

SECTION 7 INDEPENDENT MIDWIVES

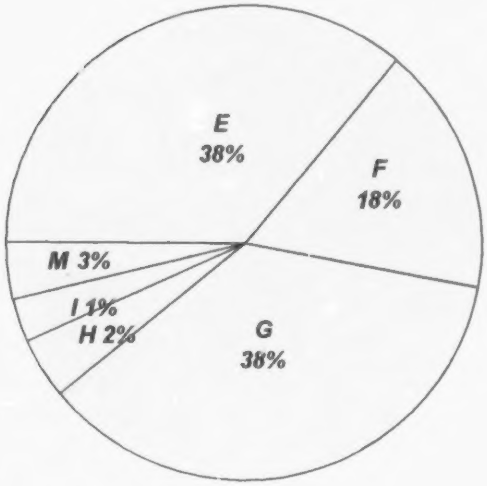
SECTION 1 RESPONSE RATES AND BACKGROUND OF NHS MIDWIVES

1.1 Response Rates

Eleven hundred midwives were selected to be in the study on the basis of the method outlined in Chapter 2. Seven hundred and seventy one midwives returned completed questionnaires. A response rate of 70%. The response rates by NHS region and unit size were largely consistent.

1.2 Background of Sample of Midwives

Figure 4.1: Midwife grade (n=771)

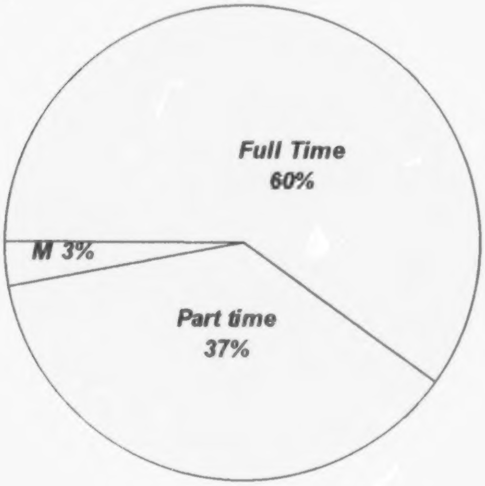


Midwives who returned questionnaires were predominantly E, F and G grades, which reflects the national picture. As only a very small percentage of midwives are on grades H and I, they have not been included in the analyses that have been undertaken by grade. However, information regarding the role and responsibilities of H and I grades has been included in Section 5.

Midwives were asked to indicate the number of hours per week they were contracted to work. A 37.5 hour week or more, was considered to be full-time. The number of hours midwives were contracted to work ranged between 10 and 40.

The percentages of full and part-time staff in this sample are similar to national figures for the United Kingdom, as in Figure 4.2(212).

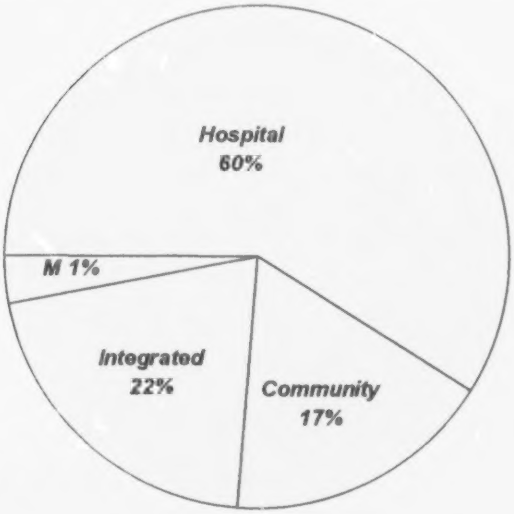
Figure 4.2: Full/part-time working (n=771)



Midwives were asked to indicate whether they personally worked in hospital only, community only or both hospital and community .

(Midwives who worked in both hospital and community settings will be referred to as 'integrated' midwives).

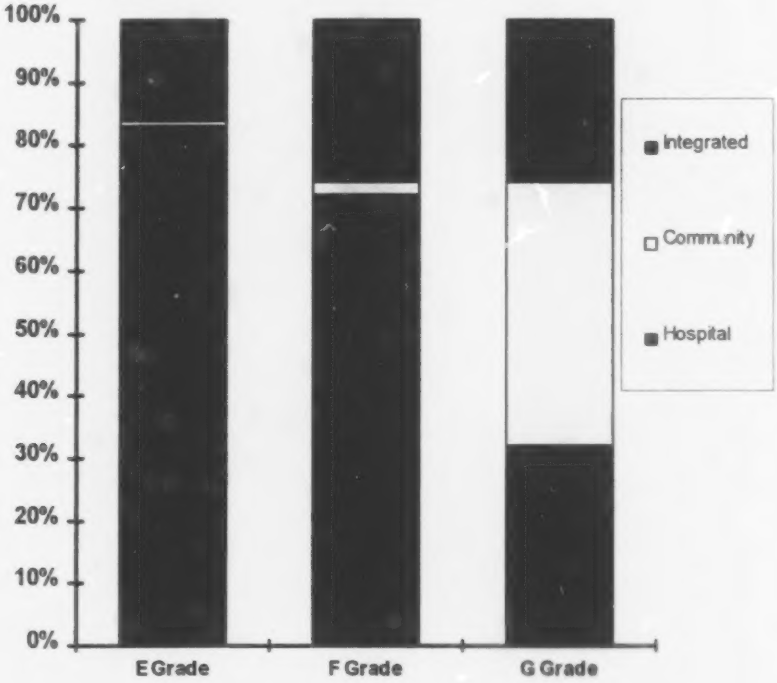
Figure 4.3: Practice base of midwives (n=771)



G grade staff were significantly more likely than E or F grades to be working full-time. E and F grade staff were more likely to be based in hospital, and G grades in the community. Nearly three quarters of the part-time staff worked in hospital.

Those who indicated that they worked in both hospital and community settings worked within a range of systems, but they tended to work within some kind of team system.

Figure 4.4: Midwife grade by practice base



* 20 midwives did not indicate their grade. Of these 20, 8 midwives did not indicate their practice base either.

**

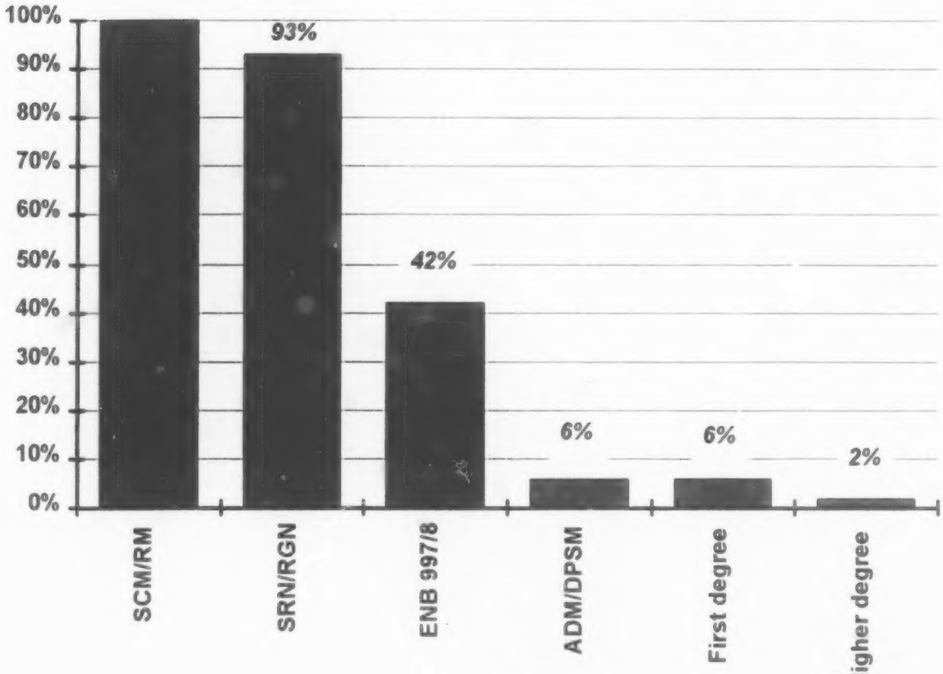
Nearly all community midwives are G grade staff, and the majority or E grade staff work in hospital. However, considerable variation of grade and practice base occurs in certain situations. For example, substantial numbers of G grades work in each of the 3 practice bases, and considerable numbers of E, F and G grade midwives work in hospital settings. Therefore, analyses have been undertaken by the main effects of practice base and grade, and where appropriate for grade effects within each practice base.

*** Where differences between groups have been outlined, only one appropriate level of significance has been reported where a number of findings all relate to a similar issue/s*

1.3 Qualifications of Midwives, Length of Time Qualified and Line Management Issues

Midwives were asked to indicate which of the following qualifications they had obtained.

Figure 4.5: Qualifications of midwives (n=771)



Those who had obtained the ENB997 or 998 were more likely to be G grade staff and working full-time($p \leq .0003$). Approximately 2% of the sample indicated that they had obtained a teaching certificate other than the ENB 997/8. Two percent indicated that they had obtained a family planning qualification. Approximately 1% reported having a diploma in nursing studies or a neonatal certificate. A very small number indicated they had qualifications in specialist counselling functions or in management issues.

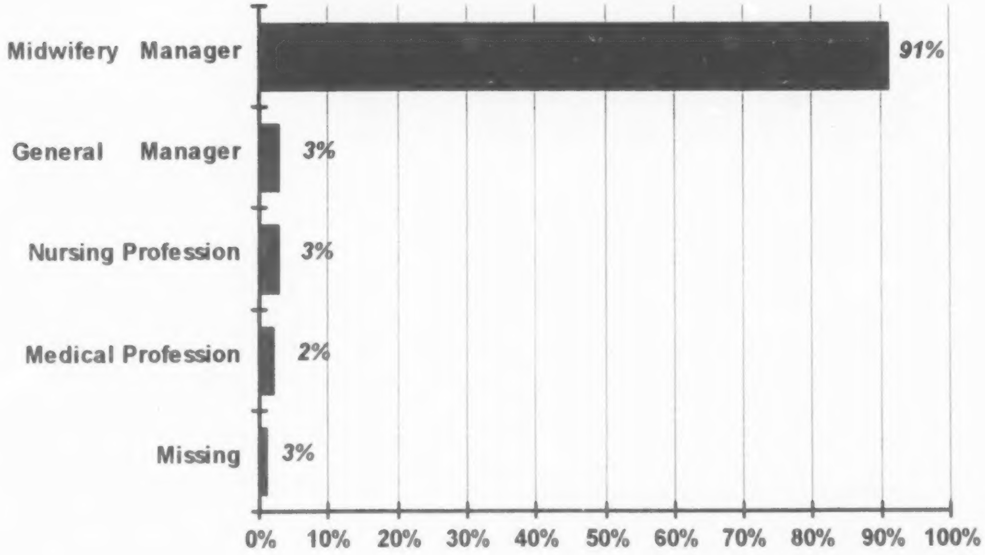
Time qualified as a midwife ranged from 2 months to 36 years with a mean of 11 years 10 months(sd = 8.6).

G grades had been qualified on average 9.5 years longer than E grades and 4 years longer than F grade staff($p<.001$).

Part-time staff had been qualified on average for 2.5 years longer than full-time staff($p<.001$). Community based midwives had been qualified on average for 5 years longer than hospital midwives($p<.001$).

Midwives were asked to indicate which of the following were their line manager.

Figure 4. 6: Midwives line manager (n=771)



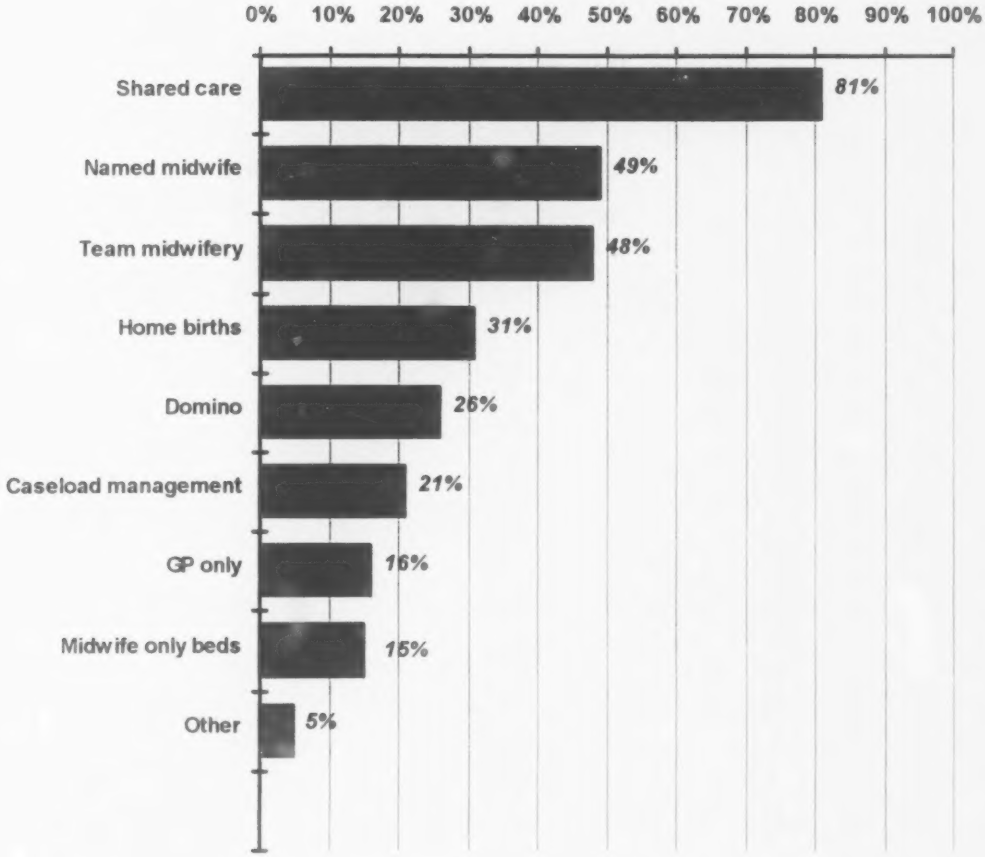
A midwifery manager was, in the vast majority of cases, the midwife's line manager.

SECTION 2 PROVISION OF MATERNITY SERVICES

2. 1 Systems of Care Provided

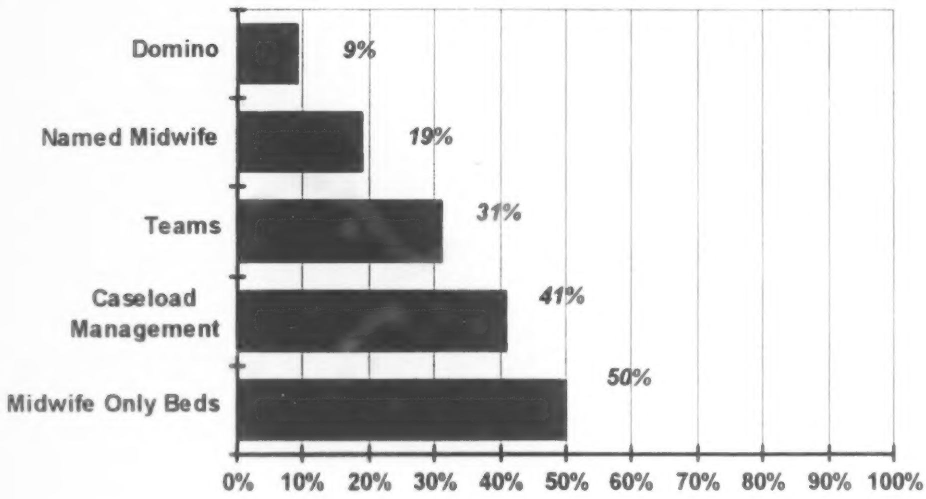
Midwives were asked which of the following systems of care they were currently involved with.

Figure 4.7: Systems of care (n=771)



Data from the supervisors indicated that plans were being introduced to implement various systems in the future.

Figure 4.8: Plans to implement systems of care (supervisor) (n=172)



Definition of terms by midwives

The domino scheme tended to operate in the way that has been conventionally defined(see 3). Community midwives cared for the woman in the antenatal period, delivered them in hospital, transferred them home within 24 hours of the birth and cared for them in the community throughout the postnatal period.

Wide variation was apparent countrywide in relation to the way team midwifery operated, which is consistent with available data sources, e.g.(3,113). Further information about the way team midwifery was defined by those taking part in this study has been presented in Chapter 5.

There was some variation apparent regarding the way caseload management operated. However, on the whole, midwives provided care for a specific group of women throughout most of the maternity period, sometimes, but not always providing intrapartum care. In some cases, the women would get to know a small team of midwives who would provide the care, in other cases one named midwife would provide most of the care with support as necessary from a partner midwife.

GP only care tended to refer to situations where the GP and the midwife between them provided all the care - including intrapartum care - which could be provided in GP beds - either in a GP unit or in an obstetric unit, or at home.

Midwife only beds tended to be allocated for domino deliveries, or for the use of low risk women in labour. The midwife would provide all the midwifery care needed and obtain medical support only if she considered it necessary.

Enormous variation existed regarding the way the named midwife system operated. It was quite common for a midwife based in the community to be the named midwife and to provide a substantial amount of the antenatal and postnatal care (with back up as necessary from other team or group practice members). Sometimes intrapartum care was provided by this midwife. However, mostly hospital based intrapartum care was not provided by the named midwife. Some hospitals allocated women a named midwife on a 'visit to visit' or 'shift by shift' basis, without any real evidence of continuity being facilitated by such a process.

Further information has been provided in Chapter 5, concerning the way in which midwives and supervisors indicated that continuity of care was addressed within the systems outlined above, and the way in which certain systems operated in conjunction with each other.

Systems of maternity care by midwives grade, practice base and full/part-time working.

F grade staff were significantly more likely to report involvement in team midwifery. E grade staff were least likely to report working in teams(p=.002).

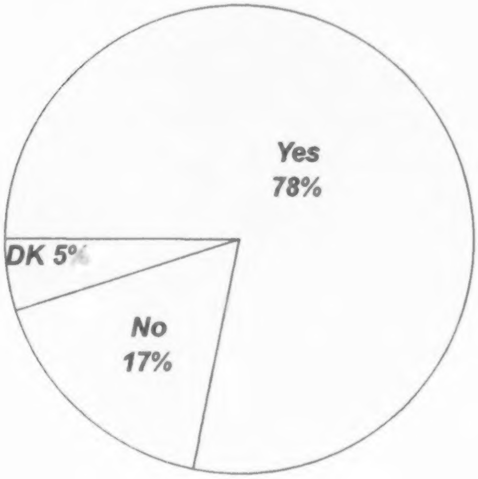
Community midwives were significantly more likely to report that they provided domino care, home births, caseload care, shared care, GP only care and acted as the named midwife($p \leq .0001$).

'Integrated' midwives reported working in teams more often than community or hospital midwives(p=.00002).

2.2 Rotation System

Midwives were asked whether a system of staff rotation was in operation.

Figure 4.9: Rotation system in operation (n=771)



Community staff were least likely to report that they worked within a system of rotation(p<.00001). The vast majority of hospital and 'integrated' midwives indicated their involvement in a system of rotation. G grade midwives were less likely than E or F grade midwives to work within a system of rotation(p<.00001).

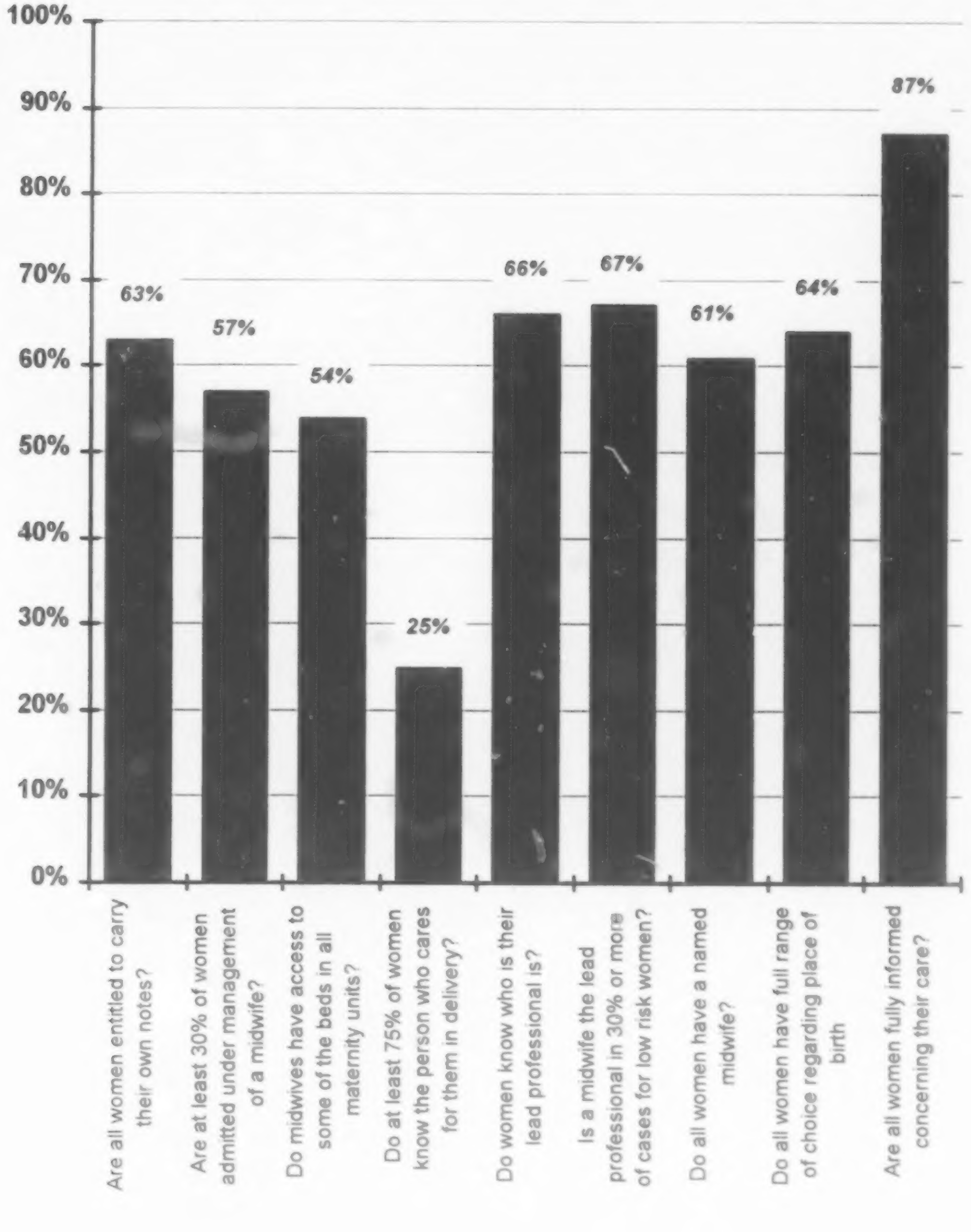
The way in which midwives and supervisors reported that the rotation system operated has been described in Chapter 5.

2.3 Implementation of Changing Childbirth

Midwives were asked to indicate whether 7 of the Changing Childbirth indicators of success had been implemented in their service. Figure 4.10 indicates the percentage of midwives who reported implementation had occurred.

The indicators are those most directly relevant to midwifery practice. In addition, midwives were asked whether women were fully informed concerning their care, and whether women had a full range of choice regarding the place of birth. Although these were not specifically indicators of success outlined in Changing Childbirth, they were key concepts running throughout the report.

Figure 4.10: Implementation of key aspects of Changing Childbirth (midwives report) (n=771)



Implementation of Changing Childbirth by midwives grade, practice base and full/part-time working.

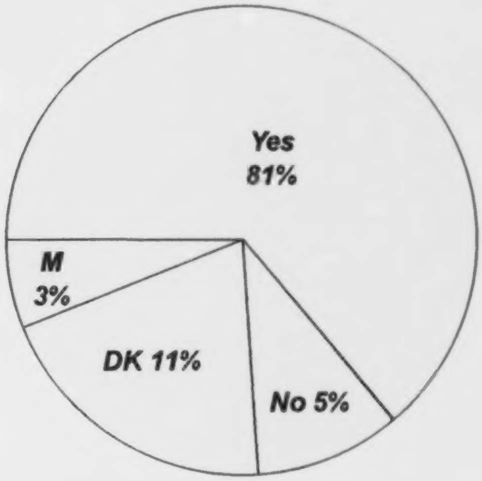
There were not many significant differences regarding midwives reporting of the implementation of Changing Childbirth in relation to grade, practice base and full/part-time working.

Community midwives were significantly more likely to report that all women had a named midwife and hospital midwives were least likely to report this practice currently occurred(p<.00001). Hospital midwives were least likely to report that women knew who their lead professional was(p=.008) and 'integrated' midwives were most likely to report that at least 75% of women knew the person who cared for them in delivery(p<.00001).

Full-time midwives were significantly more likely to indicate all women had a named midwife than part-time midwives(p=.0004).

Midwives were asked whether the implementation of the above indicators would improve the quality of maternity services.

Figure 4.11: Effect of the implementation of Changing Childbirth on service quality (n=771)



The only significant effect in relation to midwives' views regarding the potential effect of implementing Changing Childbirth arose in relation to practice base. 'Integrated' midwives were most likely to consider implementation would improve the quality of the maternity services(p=.009).

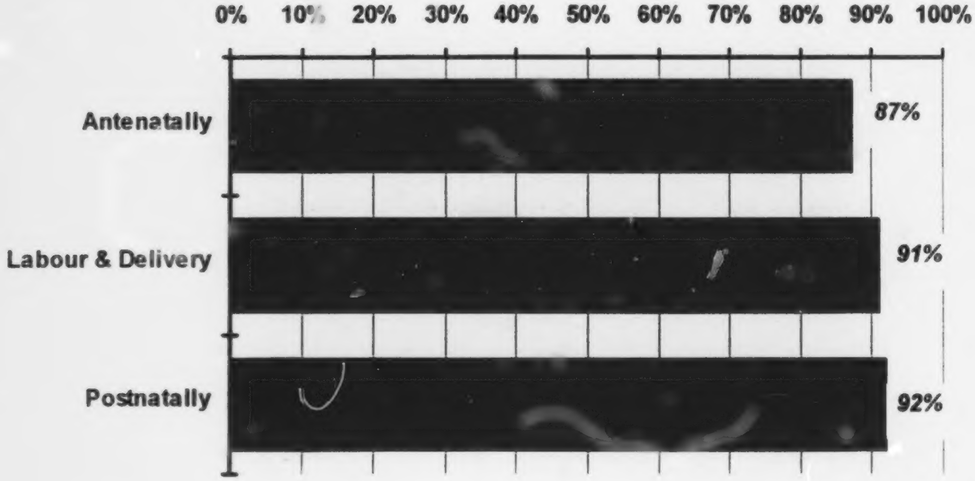
SECTION 3 ROLE AND RESPONSIBILITIES OF NHS MIDWIVES

3.1 Midwives Perceptions Regarding the Lead Professional

Midwives were asked with regard to low risk pregnancy which professional group they considered should provide a substantial part of the care personally and be responsible for ensuring women have access to care from other professionals as appropriate: (i) antenatally, (ii) in labour and delivery, (iii) postnatally (question was open ended) .

Figures 4.12 and 4.13 below indicate the percentage of midwives who indicated that the midwife should be the lead professional.

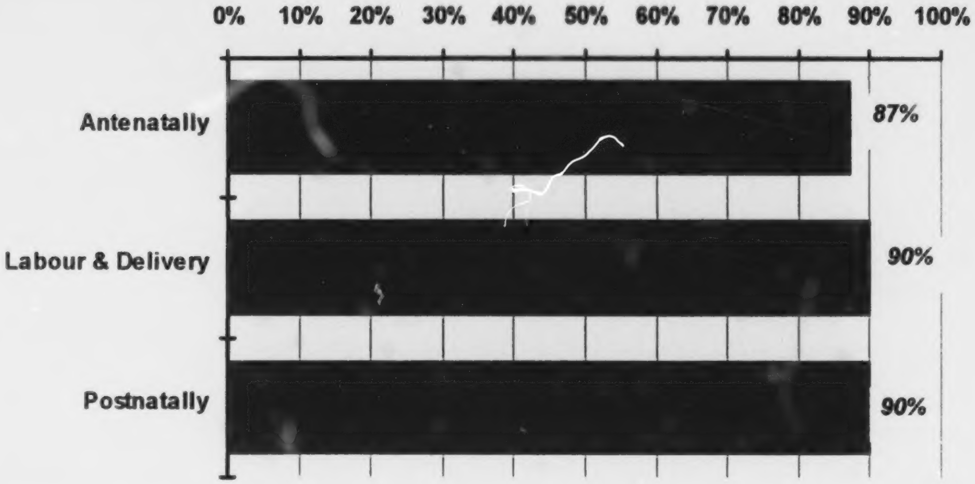
Figure 4.12: Midwife to be lead professional antenatally, in labour and delivery and postnatally (n=771)



Midwives were asked with regard to low risk pregnancy which professional group they considered should carry overall responsibility : (i) antenatally, (ii) in labour and delivery (iii) postnatally (question was open ended).

The figure below indicates the percentage of midwives who indicated that the midwife should carry overall responsibility for care.

Figure 4.13: Midwife to carry overall responsibility antenatally, in labour and delivery and postnatally (n=771)



The issues related to the lead professional and the professional carrying overall responsibility for care have been discussed further in Chapter 8.

3.2 Midwives Perceptions Regarding General Scope of Their Role and Responsibilities

Midwives were asked to indicate on a 5 point scale *(1 = not at all; 5 = completely)* to what extent their current practice reflected the full role of the midwife as outlined in the *UKCC Code of Practice(1994)*.

Table 4.1: Extent to which current practice reflects UKCC code (n=771)

Reflects UKCC code	%
5 completely	17
4	44
3	27
2	6
1 not at all	1
Missing	5
Total	100

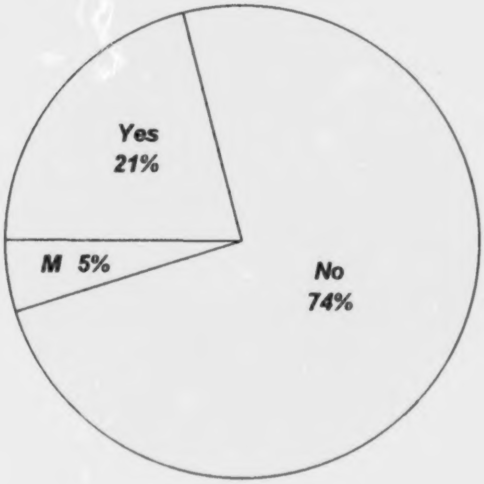
For the purposes of further analyses, the above scale was collapsed in the following way:

- 5 and 4 = largely reflects UKCC Code
- 3 = partially reflects UKCC Code
- 1 and 2 = does not really reflect UKCC Code.

Hospital midwives were least likely to consider their practice reflected the full role of the midwife(p<.00001).

Midwives were asked to indicate whether they undertook any roles that they considered to be inappropriate in their current position.

Figure 4.14: Inappropriate roles (n=771)



Midwives were also asked whether they considered there were areas of unnecessary overlap between midwives and doctors.

Figure 4.15: Unnecessary overlap with doctors (n=771)

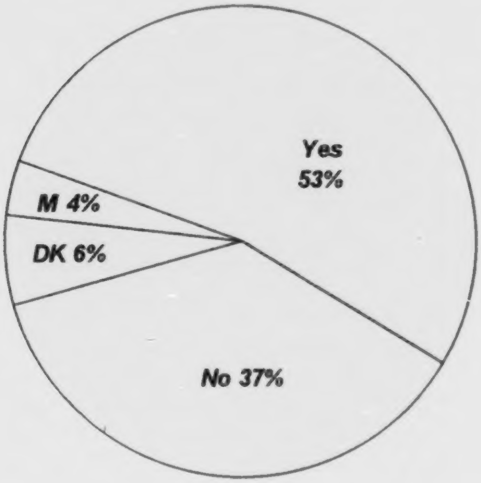
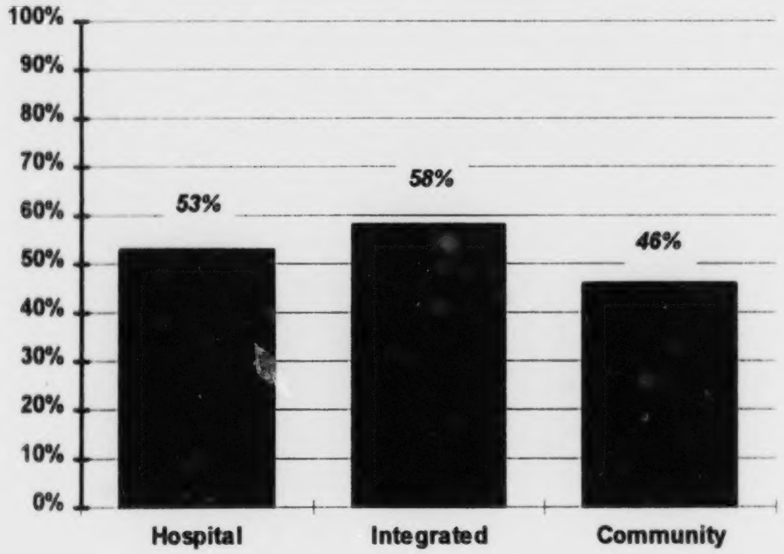


Figure 4.16: Unnecessary overlap by practice base (n=763)



Community midwives were the least likely to consider that there were areas of unnecessary overlap with doctors, and 'integrated' midwives were the most likely to consider this to be the case(p=.007).

Further information regarding the areas in which midwives considered there was unnecessary overlap between themselves and doctors, and the extent to which they considered they undertook inappropriate roles has been outlined in Chapter 5, with the findings from the other professional groups.

3.3 Social and Cultural Issues

Midwives were asked to indicate on a 5 point scale *(1 = not at all confident; 5 = very confident)* to what extent they felt confident to provide information on social and welfare issues, or to appropriately refer women on to other agencies if necessary.

Table 4.1: Confidence re: social and welfare issues (n=771)

Confidence	%
5 very	15
4	32
3	34
2	15
1 not at all	2
Missing	2
Total	100%

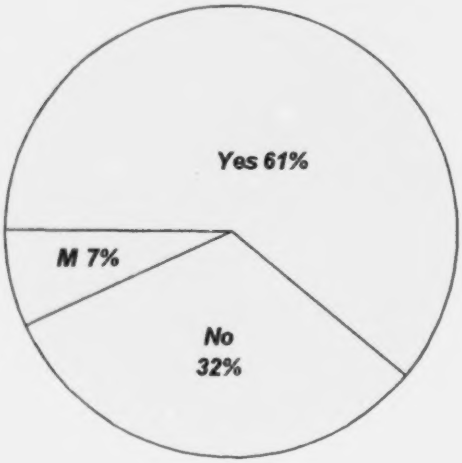
For the purposes of further analyses, the above scale was collapsed in the following way:

- 5 and 4 = confident to provide/refer regarding social and welfare issues
- 3 = confident to some extent to provide/refer regarding social and welfare issues,
- 1 and 2 = not very confident to provide/refer regarding social and welfare issues.

Community midwives reported that they were the most confident to provide women with information on social and welfare issues or to refer as appropriate, followed by 'integrated' midwives. Hospital staff were the least confident in this respect(p=.001). G grade hospital and 'integrated' midwives reported that they were more confident in this respect than their E and F grade colleagues(p=.0003). Full-time midwives were more confident in this respect than part-time midwives(p=.002).

Midwives were asked to indicate whether they provided women with social support during pregnancy.

Figure 4.17: Provision of social support (n=771)



Community midwives were most likely to indicate that they provided social support, followed by 'integrated' midwives. Hospital staff were least likely to provide social support, with approximately half of those based in hospital reporting that they provided this aspect of care(p<.00001).

Midwives were asked to give examples from practice of how they provide women with social support

Fifty eight percent of midwives provided examples of the ways in which they provided social support to women. Approximately a third of those who commented indicated that they made extra time for women who needed support through extra home visits, a drop in clinic or by setting a certain amount of time aside during parentcraft classes for discussions with women. Almost half referred women to social workers as appropriate, and a third indicated that they referred women to support groups such as the Stillbirth and Neonatal Death Society (SANDS) or counselling groups when they considered that this would be helpful.

Midwives were asked to indicate on a 5 point scale (1 = not at all confident; 5 = very confident) the extent to which they considered themselves confident to meet the needs of individuals from a range of social backgrounds.

Table 4.2: Confidence to meet the needs of individuals from a range of social backgrounds (n=771)

Confidence	%
5 very	30
4	49
3	17
2	2
1 not at all	1
Missing	1
Total	100

Those working in hospital were less likely than community or 'integrated' midwives to consider themselves confident to meet the needs of women from a range of social backgrounds(p=.04).

Midwives were asked to indicate on a 5 point scale (1 = not at all confident; 5 = very confident) the extent to which they considered themselves confident to meet the needs of individuals from a range of cultural backgrounds.

Table 4.3: Confidence to meet the needs of individuals from a range of cultural backgrounds (n=771)

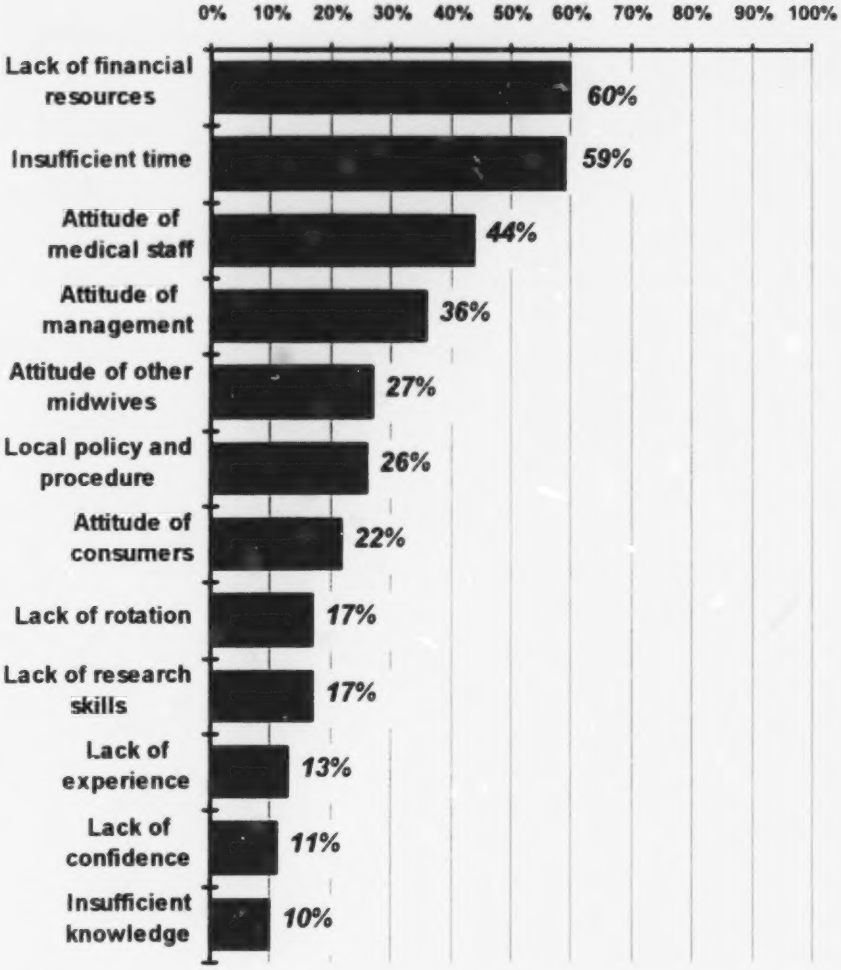
Confidence	%
5 very	13
4	35
3	35
2	13
1 not at all	2
Missing	2
Total	100

Full-time midwives were significantly more likely than part-timers to consider themselves confident to meet the needs of midwives from a range of cultural groups(p=005). Communication difficulties, particularly in relation to language, was the most frequently identified problem. A lack of regular contact with women from certain backgrounds often left midwives feeling rather inadequate concerning their ability to provide appropriate care in a range of circumstances.

3.4 Factors Which Prevent Midwives from Carrying Out Their Full Role, and Facilitating Women's Choices

Midwives were asked whether any of the following prevented them from carrying out the full range of activities for which they are trained.

Figure 4.18: Barriers to practice (n=771)



It is interesting to note that a lack of confidence and insufficient knowledge were only mentioned by a minority of midwives but later on in the questionnaire a substantial number of midwives indicated that they lacked confidence in a number of areas related to potential midwifery activities. Also, a lack of research skills was fairly low down on the list, although later questions indicated that a high proportion of midwives considered research skills to be important in midwifery practice and a substantial number of midwives identified research as an area for continuing education

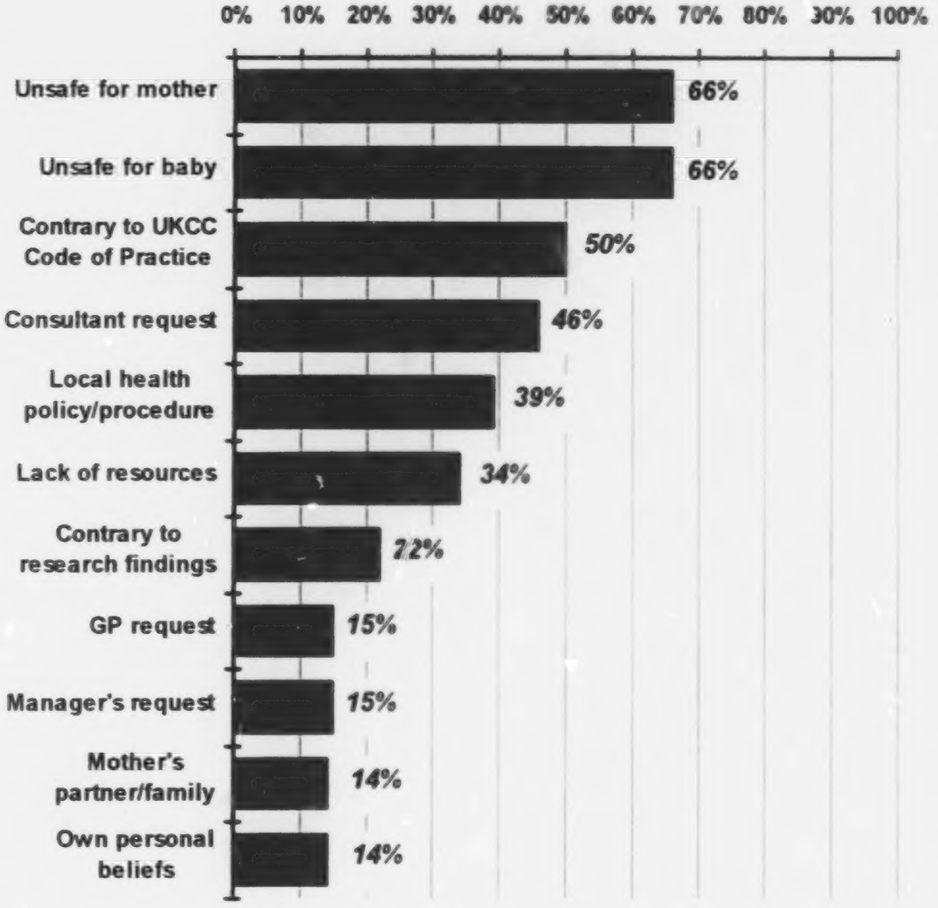
A lack of financial resources and insufficient time were the main barriers identified to midwives undertaking their full role. However, a minority of the sample identified several other potential barriers to practice, with E grade staff being most likely to identify several barriers. Just over 40% of E grades considered the attitude of management a potential barrier, approximately a third identified the attitude of other midwives, and approximately a quarter considered a lack of experience and a lack of rotation opportunities potential barriers. Approximately one in five E grade midwives indicated that a lack of confidence/assertiveness prevented them from undertaking the full range of activities for which they are trained(p<03).

Approximately a quarter of part-time midwives identified a lack of rotation opportunities as a potential barrier to practice, whereas only 15% of full-time midwives considered this to be the case(p=.007). Fourteen percent of the part-time staff and 9% of full-time staff considered that a lack of confidence/ assertiveness prevented them from undertaking the full range of activities for which they have been trained(p=.04).

Hospital and 'integrated' midwives were more likely to report that the attitude of management prevented full practice than community midwives. Approximately 40% of hospital and 'integrated' midwives identified this as a barrier to practice(p=.03). Hospital midwives were more likely to indicate that the attitude of consumers constituted a barrier to practice, with approximately a quarter considering this to be the case(p=.005)

Midwives were asked whether any of the following prevented them from supporting women in their choices throughout childbirth.

Figure 4.19: Factors preventing midwives supporting women's choices throughout childbirth (n=771)



E grade hospital midwives were more likely than F or G grade hospital midwives to consider local health policies and procedures prevented them from fully supporting women's choices in childbirth. Approximately half the sample of E grade hospital midwives identified this as a potential barrier(p=.003).

With regard to practice base, 'integrated' midwives were more likely to consider that GP requests prevented them from facilitating women's choices, with approximately a quarter of 'integrated' midwives reporting this to be the case(p<.00001). Community midwives were least likely to consider consultant request prevented them from facilitating women's choices(p<.00001).

In summary, E grade midwives and those who worked part-time were more likely to identify multiple barriers to practice. With regard to practice base, community midwives identified the least barriers to practice.

Midwives were asked to provide examples from their practice of ways in which they facilitated the choices the woman/her family had made for childbirth.

Three quarters of the sample provided examples of ways in which they facilitated women's choices. Four in ten of those who commented reported that they had a discussion with the woman and her family to provide information about available choices, and to facilitate the woman in making informed choices about their care Approximately one third encouraged women to write a birthplan that would be used, as far as possible, to inform care throughout pregnancy and childbirth. Approximately a quarter reported that they enabled women to labour and deliver in alternative positions, and to choose a wide range of methods of pain relief, including alternative methods such as transcutaneous electrical nerve stimulation (TENS). Fifteen percent indicated that they supported women in their choice for the place of birth, particularly home birth.

These two quotes from midwives exemplify some of the thinking:

"One client wished to change from hospital to domino. I liaised with the hospital and informed them of the change, told GP of her wishes - he is not supportive, so arranged transfer to another GP for delivery cover. I have visited her at home 3 times so far to discuss delivery".

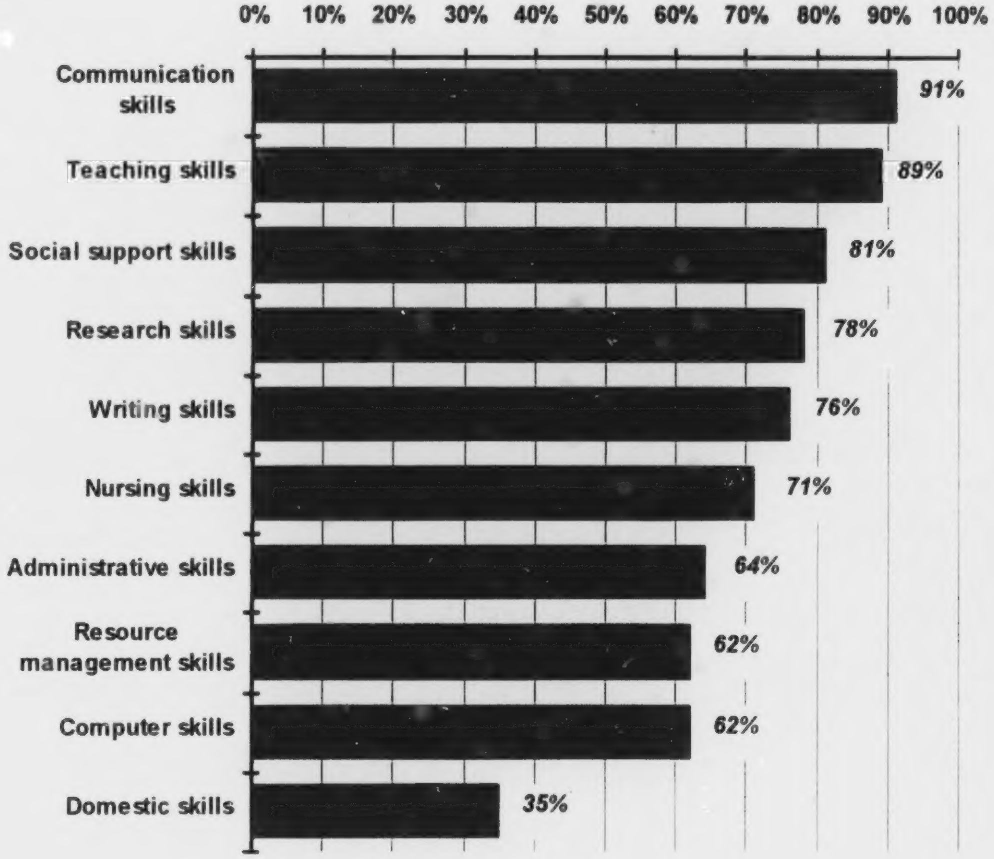
"Always give support whatever their choice - but if I do not agree with what they want, I explain why and back up with research - thus giving them an informed choice".

Smaller numbers commented on a broad range of ways of facilitating choices, including allowing women the choice of people to support them during delivery, discussing the woman's choice with doctors, generally having a flexible attitude, acting as the woman's advocate and giving women the choice of being monitored during labour. A very small number mentioned providing continuity of care where possible, and one midwife commented that implementing Changing Childbirth was a way of facilitating choice.

3.5 Skills and Attributes Important for Midwifery Practice

Midwives were asked which of the following skills midwives who regularly provide care require.

Figure 4.20: Skills required by midwives (n=771)



On the whole, midwives tended to be in broad agreement about the relevance of many of these skills, showing more variation in relation to resource management, computer skills and administrative skills. Domestic skills was the only one selected by less than a majority of the sample, with just over a third considering them necessary. There were no differences by grade, full or part-time working or practice base.

Midwives were asked which of the following do midwives who regularly provide care need to be.

Table 4.4: 'Attributes' appropriate for midwives (n=771)

Appropriate Attributes	%
Flexible	96
Good team worker	95
Decisive	87
Reflective	83
Assertive	83
Autonomous	68
Analytical	63
Creative	53
Respectful of authority	45
Nurturant	43
Independent	42
Authoritative	24
Dressed in uniform	18
Conformist	10

Table 4 .5: Training background appropriate for midwives (n=771)

Appropriate Background	%
Trained in needs of ethnic groups	71
Trained as a nurse	37

111

Being flexible and a good team worker were the two most important 'attributes' selected. It is interesting to note that independent, creative, nurturant and respectful of authority were all selected by around half the sample indicating a clear diversity of views amongst midwives regarding the desirability of certain attributes and/or characteristics in relation to practice.

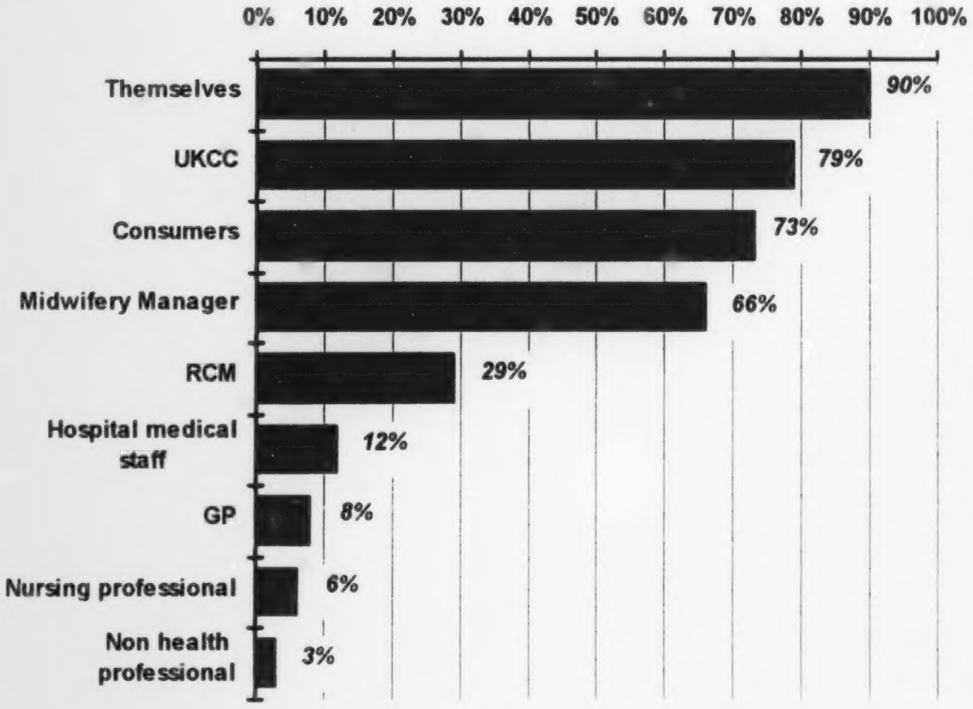
There were few differences regarding midwives perceptions of the attributes/skills required for practice by grade, practice base or full/part-time working. E grades were less likely than F or G grades to consider midwives needed to be autonomous(p=.02).

Full-time midwives were more likely to consider it important to be creative, reflective, trained in the needs of ethnic groups, and part-time midwives were more likely to think it important to be respectful of authority($p \leq .04$)

3.6 Midwives Accountability

Midwives were asked to select from the following list to whom they considered they should be accountable.

Figure 4.21: Midwives accountability (n=771)



Other n=5

3.7 Aspects of Care Provided by Midwives

Midwives were asked to indicate whether they personally provided the following aspects of care in their current post.

Table 4.6: Aspects of care provided by midwives (antenatal) (n=771)

Aspects of Care (Antenatal)	%
Lifestyle advice (e.g. diet, smoking, exercise, alcohol)	92
Monitoring normal pregnancy	80
Providing parenthood education (antenatally)	69
Advising on examinations for earliest diagnosis of pregnancy at risk	50
Diagnosis of Pregnancy	13

Table 4.7: Aspects of care provided by midwives (intrapartum) (n=771)

Aspects of Care (Intrapartum)	%
Providing care for mothers during labour	92
Delivery in alternative positions	90
Conducting spontaneous deliveries in hospital	88
Alternative methods of pain relief in labour (e.g. Tens)	87
Assisting with a Caesarean section	57
Conducting a breech delivery (in an emergency)	50
Conducting spontaneous deliveries at home	34
Manual removal of placenta (in emergency)	20

Table 4.8: Aspects of care provided by midwives (caring for newborn) (n=771)

Aspects of Care (Newborn)	%
Examining and caring for the newborn	94
Advising mother on infant care	94
Carrying out resuscitation of the newborn	88

Table 4.9: Aspects of care provided by midwives (mother postnatally) (n=771)

Aspects of Care (Postnatal)	%
Advising on family planning	85
Caring for mother postnatally in hospital	79
Caring for mother postnatally at home	41

Table 4.10: Aspects of care provided by midwives (medical aspects and record keeping) (n=771)

Aspects of Care (Medical/Record-keeping)	%
Recognising the need for medical assistance	97
Maintaining all necessary records	97
Carry out treatment prescribed by a doctor	95
Taking emergency measures in absence of a doctor	84

Table 4.11: Aspects of care provided by midwives (total/autonomous) (n=771)

Aspects of Care (Total/Autonomous)	%
Providing total care to low risk women	51
Full antenatal care autonomously to low risk women	42

Over 70% of midwives reported providing all the following aspects of care: maintaining all necessary records, recognising the need for medical assistance, carrying out treatment prescribed by a doctor, advising mothers on infant care, examining and caring for the newborn, providing care in labour, providing lifestyle advice, delivery in alternative positions, resuscitation of the newborn, alternative methods of pain relief in labour, conducting spontaneous deliveries in hospital, advising on family planning, taking emergency measures in absence of doctors, monitoring normal pregnancy and caring for the mother postnatally in hospital.

These aspects of care are either directly included in the activities of a midwife (UKCC)(9) or they potentially fit within this framework. For example, one of the activities of a midwife is "to care for and assist the mother during labour" and another is to "conduct spontaneous deliveries". Delivery in alternative positions and alternative methods of pain relief may well be important components of the care required during labour and delivery if women's choices are to be facilitated.

It is interesting to note that only around half of the sample considered that they provided total care to low risk women, and under half considered that they provided full antenatal care autonomously to low risk women. It was apparent that midwives' perceptions varied regarding what is meant by providing antenatal care autonomously to low risk women, and providing total care to low risk women.

Some midwives considered they were providing full antenatal care *autonomously* when they provided all the *midwifery* care required, even though a doctor might still be involved in providing other aspects of maternity care. However, other midwives only considered they provided care *autonomously* if a doctor was not involved in care provision at all.

On the whole, providing total care to low risk women appeared to relate to providing all the *midwifery* care required by women antenatally, during labour and delivery and postnatally. However, this did not necessarily mean all care was provided by the *same* midwife for the *same* woman. Also, sometimes it seemed that providing total care meant providing all the midwifery care required in the *specific* setting in which a midwife worked e.g. the delivery suite.

It may also be of significance to note that despite the high proportion of midwives providing care during labour and conducting spontaneous deliveries, other aspects of the data indicates that this may not happen on a very regular basis, even though it may be part of the overall responsibilities within the job.

There were some significant differences with regard to the aspects of care provided, by practice base.

Midwives based in the hospital were obviously less likely to report that they provided care in the home. They were also less likely to report providing *parenthood education antenatally (see Figure 4.22), full antenatal care autonomously to low risk women (see Figure 4.23), and total care to low risk women (see Figure 4.24)* ($p<.00001$).

Although the majority of hospital midwives monitored normal pregnancy and provided family planning advice, community and 'integrated' midwives were more likely to report involvement in providing such aspects of care($p<.00001$). Over half the community and 'integrated' midwives reported that they conducted a breech delivery (in a emergency), whereas under half the hospital sample indicated that they were likely to be involved in such an activity($p=.02$).

Community midwives were obviously most likely to report that they provided postnatal care in the home and were least likely to report that they provided postnatal care in the hospital($p<.00001$).

'Integrated' midwives tended to fall somewhere in between the hospital and community midwives in relation to providing many of these aspects of care.

Figure 4.22: Provision of parenthood education (antenatally) by practice base (n=763)

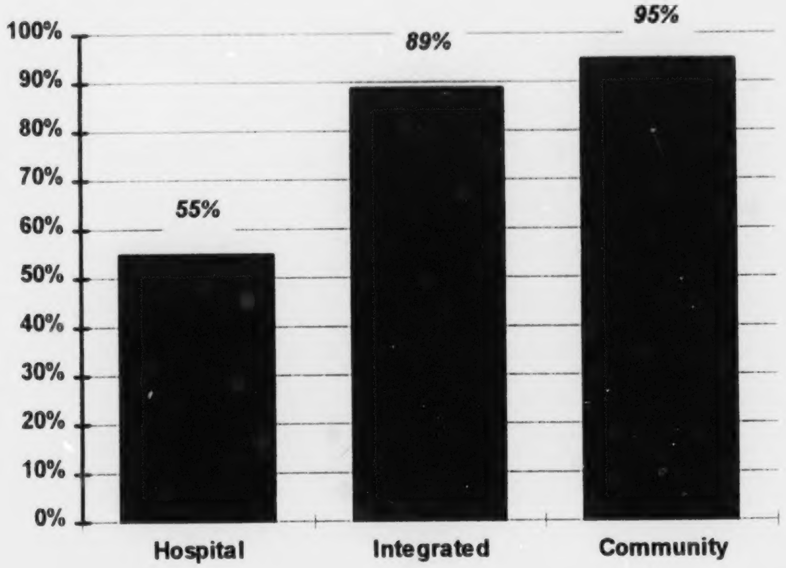


Figure 4.23: Provision of full antenatal care autonomously to low risk women by practice base (n=763)

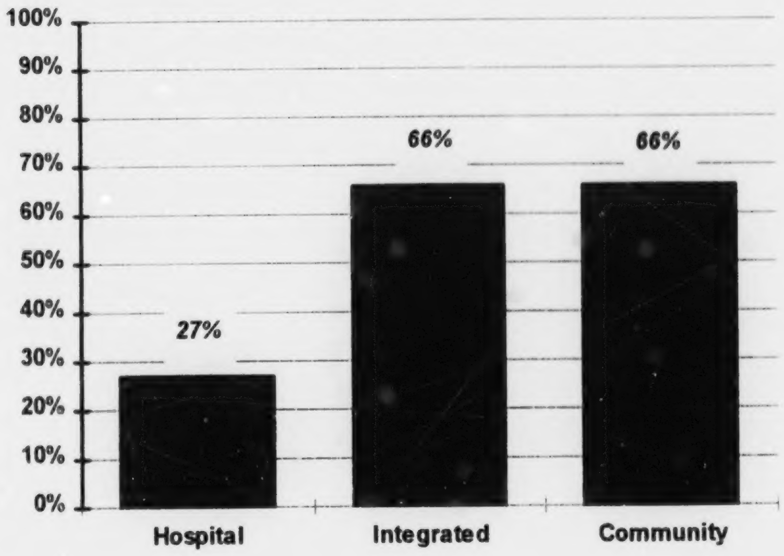
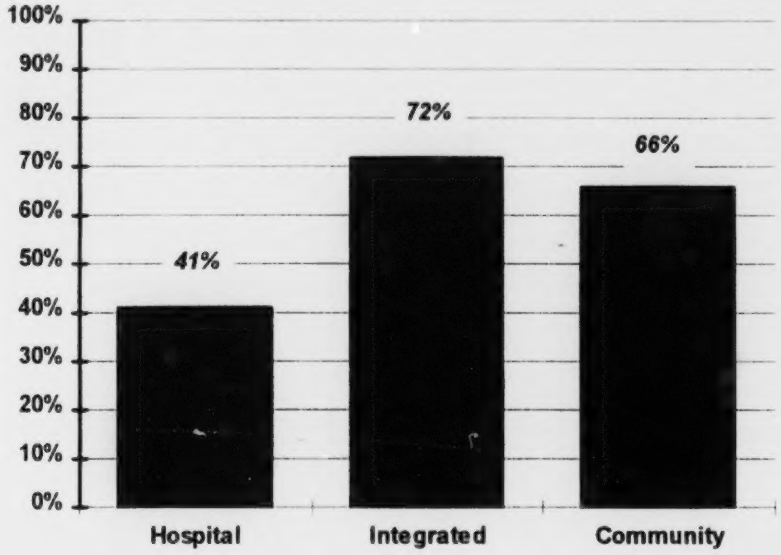


Figure 4.24: Provision of total care to low risk women by practice base (n=763)



Within the 'integrated' group, E grades were least likely to report that they provided domino care and home births(p≤.006). 'Integrated' E grades were obviously much more likely than hospital based E grades to report that they provided such care. 'Integrated' E grades were also more likely to report that they provided full antenatal care autonomously to low risk women(p=.00003), and that they provided total care to low risk women than their hospital based colleagues(p=.004). See Figures 4.25 and 4.26 below.

Figure 4.25: E Grade midwives - provision of full antenatal care autonomously to low risk women by practice base (n=293)

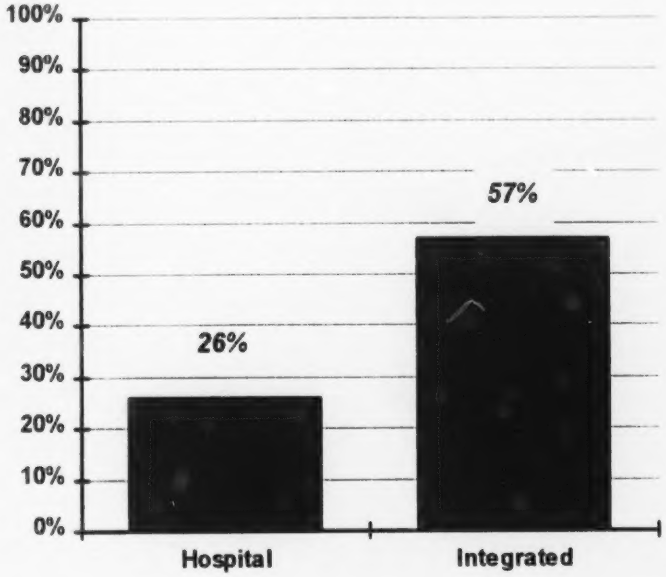
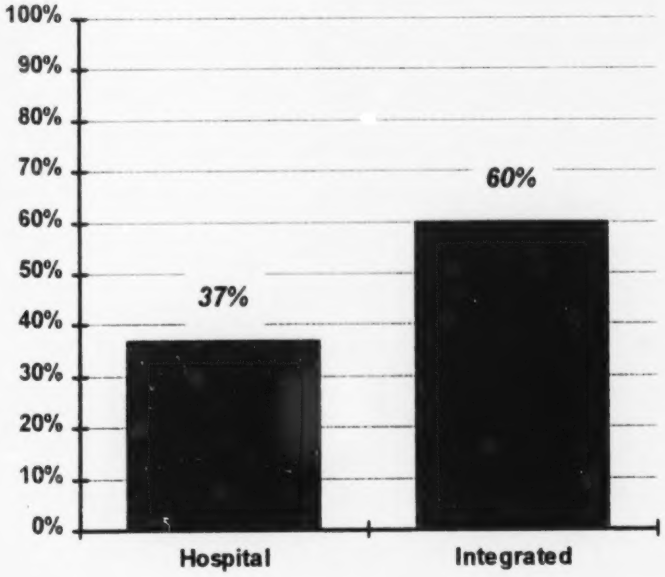


Figure 4.26: E Grade midwives - provision of total care to low risk women by practice base (n=293)



There were some differences between full and part-time staff concerning the aspects of care they reported that they provided. Part-time midwives were more likely to work in hospital, therefore they were less likely to provide care in the home setting($p<.00001$). They were also less likely to report that they provided full antenatal care autonomously to low risk women($p=.04$).

Approximately three quarters of the full-timers reported that they provided parenthood education antenatally, whereas just under two thirds of the part-timers reported that they were involved in this activity($p=.0004$).

Just under half the part-timers reported that they advised on earliest diagnosis of pregnancy at risk and provided total care to low risk women, whereas over half of the full-timers reported involvement in such activities($p\leq.004$).

Finally, although the majority of hospital based midwives reported caring for the mother postnatally in hospital, part-timers were more likely than full-timers to report that they did so($p=.0003$).

3.8 Enhanced Role Activities

Midwives were asked to indicate whether they currently provided any of the following in their current post.

Table 4.12: Enhanced role activities (n=771)

Enhanced Role	%
Interpretation of CTG	81
Application of fetal scalp electrodes	81
Perineal suturing	75
Epidural top ups	60
Labour in water	47
Labour and delivery in water	25
IV cannulation	23
Ultrasonography	9

Full-time midwives were more likely than part-time midwives to report that they provided labour and delivery in water. Approximately one in three full-timers and one in five part-timers provided such care(p=.004).

Hospital and 'integrated' midwives were significantly more likely to report that they provided epidural top-ups, applied fetal scalp electrodes and interpreted cardiotocographs (CTG's) than community midwives(p<.00001). 'Integrated' midwives were most likely to report that they provided labour in water(p=.003).

F and G grade hospital midwives were more likely to report that they provided labour and delivery in water than E grade hospital midwives(p=.03).

G grade hospital midwives were more likely than E or F grade hospital midwives to provide care in relation to IV cannulation(p=.04).

3.9 Counselling Skills

Midwives were asked to indicate whether they provided counselling in any of the following areas:

Table 4.13: Involvement in counselling (n=771)

Type of Counselling	%
Counselling in the puerperium	72
General counselling	67
Counselling re: antenatal screening	60
Bereavement counselling	60
Counselling re: complicated deliveries	60
Counselling re: complicated pregnancies	56
Counselling re: smoking cessation	54
Preconceptual counselling	18
Counselling re: HIV/AIDS	12

In general, a consistent pattern emerged in relation to G grade staff being most likely to indicate involvement in relation to providing counselling related activities(p≤.003). In addition, F grade midwives were more likely than E grades to report involvement in relation to counselling for antenatal screening and for complicated deliveries(p=.05).

Full-time midwives were significantly more likely to report that they provided counselling in relation to antenatal screening than part-time midwives(p=.003). Although there were no other statistically significant findings, there was some indication of a consistent pattern emerging in relation to full-time staff being more likely to report involvement in most of the counselling activities.

Although the majority of midwives in all practice bases reported that they provided general counselling, community and 'integrated' midwives were significantly more likely to report that they provided counselling in a range of areas including: HIV/AIDS, bereavement, for antenatal screening, for complicated pregnancies, for complicated deliveries, general counselling and counselling in relation to smoking cessation(p≤.00006). Community midwives were most likely to indicate involvement in preconceptual counselling and counselling in the puerperium (p<.00001).

G grade hospital midwives were less likely to report involvement in a range of counselling activities than G grade community and 'integrated' midwives(p≤.02).

3.10 Confidence of Midwives to Provide Care

Midwives were asked: if they did not feel confident to provide any of the above aspects of care (as outlined in Sections 3.7 - 3.9), to indicate why.

Just over half of the midwives commented. Approximately half of those who commented did not feel confident in at least one of the following areas: *ultrasonography, intravenous cannulation (IV) and labour and delivery in water.* A quarter specifically mentioned that they did not have enough opportunities to practise skills in relation to epidural top up and perineal suturing. More than a third indicated a lack of confidence in relation to counselling.

In relation to labour and delivery in water, one midwife commented:

"I personally do not think this is a safe procedure for the midwife as much as the mother. I wish to work as a midwife until my retirement. I think the risk of HIV infection from the water is unacceptable...".

Approximately a quarter indicated that they lacked confidence in relation to providing care in high risk situations, such as manual removal of a placenta or a breech presentation.

Views were rather mixed in relation to learning new skills. Some midwives felt under pressure to provide care within a broad framework in order to justify their continuing role, whereas others considered that they would like to be able to learn new skills in order to provide all the care required by women. The way that midwifery care had been organised in the past led to some midwives feeling that skills had been rather compartmentalised, which left them without the expertise required in all practice areas.

The following quotes from midwives indicate the tenor of comments received about midwives providing enhanced role aspects of care:

"We are already overstretched, the doctors should do their part".

"IV cannulation - I would really appreciate training in this area as it should be an essential part of the midwife's role, as it is often us who are first in line in an emergency situation".

Community midwives were more likely to lack confidence in relation to *providing* enhanced role aspects of care, such as epidural top ups and CTG interpretation. Hospital midwives were more likely to lack confidence in relation to *interpreting CTG's* and in providing counselling.

Finally, being *overworked and understaffed* was frequently identified as preventing midwives from having enough time to work within specific areas to promote adequate levels of confidence. Lack of time and resources were also considered a barrier to the continuing education of midwives.

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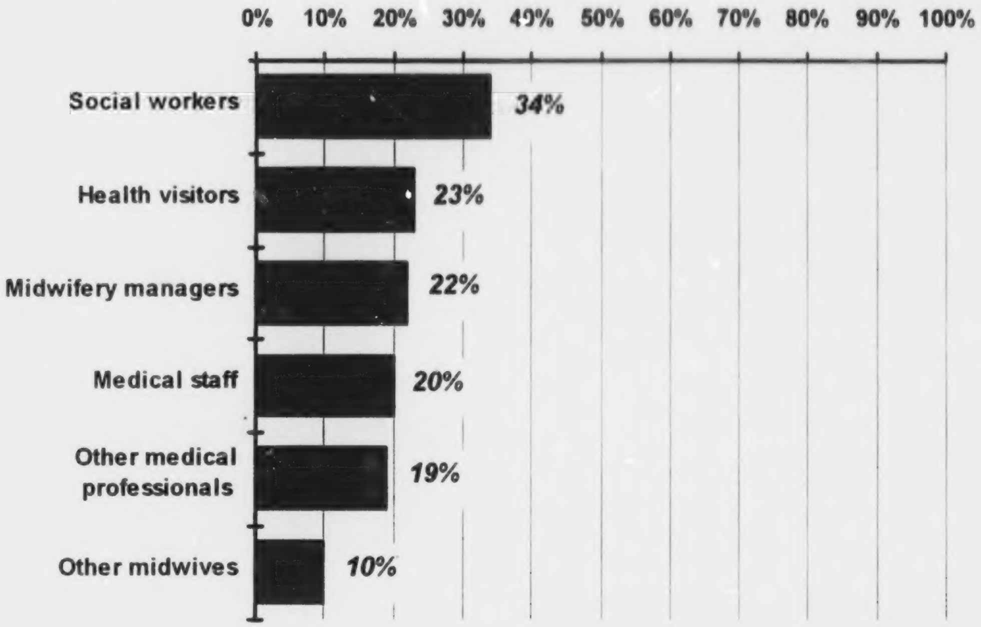
The continuing education and training needs identified by the midwives have been reported in detail in Chapter 5 with the information provided by the supervisors.

Midwives were asked if they would like any further training or assistance regarding the development of professional relationships with the colleagues outlined.

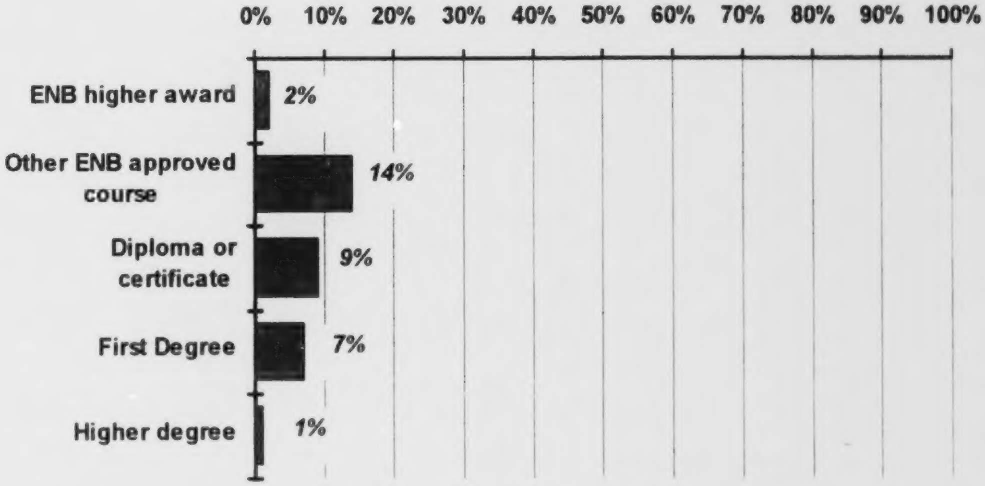
Figure 4.27: Training to develop professional relationships (n=771)



E and F grade staff were significantly more likely to indicate that they required assistance with the development of professional relationships with social workers(p=.0005). E and F grade hospital and 'integrated' midwives were significantly more likely to require help with the development of professional relationships with health visitors(p=.0007).

Midwives were asked whether they were currently registered for any of the following education opportunities.

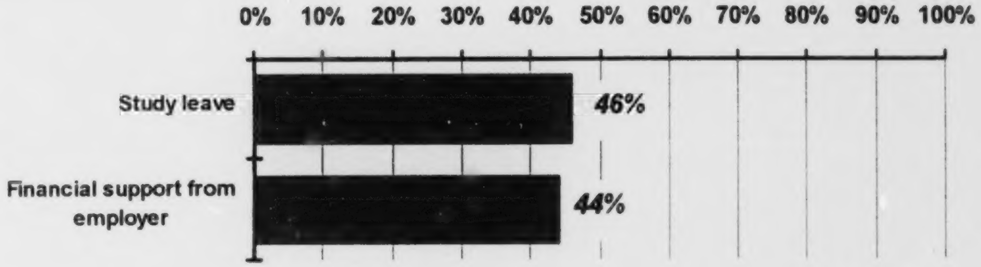
Figure 4.28: Midwives currently registered for further education (n=771)



Around one third of midwives were registered for continuing education and the majority of these were registered for an ENB approved course.

If midwives were registered for continuing education they were asked if they were supported by their employer.

Figure 4.29: Education supported by employer (n=262)



Sixteen percent of those undertaking further study were using open/distance learning methods. E grade midwives, full-time and hospital midwives were more likely to want the package that was being developed to have credit rating($p \leq .02$).

SECTION 5 H AND I GRADE MIDWIVES

There were fifteen H grades and five I grades in the sample. These midwives primarily undertook a management role and were accountable for staff management, resourcing, and budgets, with a key role in the development and monitoring of the service.

The findings in relation to the implementation of Changing Childbirth were broadly similar to those from the rest of the midwife sample. These midwives usually had some involvement in providing care to women, although rather less so than the other midwives in the sample, and they generally identified less barriers to practice.

SECTION 6 ANALYSIS BY SIZE OF UNIT

Data were analysed according to whether midwives worked in a small, medium or large unit. (Analyses were undertaken on 10 small units, 37 medium units and 13 large units. See chapter 2 for further details). Very few differences were found in relation to midwives' practice.

The attitude of medical staff and insufficient time was indicated more by midwives in small units as a potential barrier to practice($p=.004$). Midwives in large units were more likely to consider that a lack of time constituted a barrier to practice($p=.02$). Midwives in small units were also less likely to consider midwives need to be good team workers, or trained to use computers($p\leq.02$).

Midwives in medium size units were more likely than those in either small or large units to report that they provided a range of enhanced role aspects of care including IV cannulation, perineal suturing, application of fetal scalp electrodes and interpretation of CTG's($p\leq.02$). They were also more likely to report involvement in some counselling related activities.

It may be that there is greater medical involvement in the provision of maternity care in both very large and very small units. However, on the whole, very few differences emerged in relation to unit size, suggesting a reasonably uniform picture of care provision in relation to the unit size countrywide.

SECTION 7 INDEPENDENT MIDWIVES

Throughout this section the independent midwives results have been compared with the NHS sample of midwives.

7.1 Background of Independent Midwives

7.1.1 Response rates

Independent midwives in England whose names were included in the Register of Independent Midwives, or whose name was provided by a supervisor at local level, were each sent a questionnaire. Fifty five midwives returned a completed questionnaire. A response rate of 75%. Over half the midwives who returned questionnaires were from the North and South Thames NHS regions.

7.1.2 Qualifications

Qualifications of the independent midwives were broadly similar to midwives in the NHS sample. However, a significantly higher number of the independent midwives had obtained a first degree(p<.00001) and had completed a diploma in midwifery (ADM or DPSM)(p<.005). A higher number of the NHS sample had obtained the ENB 997/8 certificate and were trained as a nurse(p≤.0001).

7.2 Provision of Maternity Services

Independent midwives were less likely than the NHS midwives to provide shared care. However, they were more likely to be involved in caseload management(p<.00001).

When asked to identify the systems in place to ensure continuity of care, 65% indicated women would be cared for by the same person, or their partner, as the independent midwives work alone or within a partnership, and they are available over a 24 hour period. Other means identified for ensuring continuity included women carrying their own notes, and discussions with women regarding their plans and wishes for the birth. One midwife commented:

"As an independent midwife women choose me to be their midwife and I am their primary care giver."

The majority of independent midwives considered the implementation of Changing Childbirth would improve the quality of maternity services. This is similar to the NHS sample of midwives.

Thirty one percent of the independent midwives commented on the implementation of Changing Childbirth. Comments mostly focused around the need for the NHS to support midwives to be more autonomous by allowing midwives to fully inform women and fully support their choices. The need for NHS midwives to be prepared to work in a more flexible way to support the changes, particularly as choices increase for women was also identified. Other comments made by a small number of midwives included doctors hindering women's choices by blocking home births, NHS midwives working in very large teams that are not conducive to facilitating continuity of care, and independent midwifery being restricted by budgetary considerations.

One midwife commented:

"There needs to be alongside these targets the reskilling of midwives to be competent practitioners, organisational change to facilitate these changes and new funding routes for a change of employment opportunities for midwives from their monopolistic employers."

Another comment identified the important part the midwife plays in relation to implementing the changes.

"Without the willing involvement of midwives change will not happen. I believe that only a minority of midwives are prepared to work like this and to enable change - it is very depressing."

The influence of the consultant was commented on by one midwife as:

"Maternity units are paying lip service to Changing Childbirth mainly because consultants are reluctant to relinquish their role in favour of total midwifery care."

7.3 Role and Responsibilities of Independent Midwives

Independent midwives were more likely to indicate that their practice reflected the full role of the midwife as outlined in the UKCC Code of Practice. However they were more likely to consider they were involved in inappropriate roles than NHS midwives($p \leq .02$).

Midwives were asked to explain their answer if they considered they undertook any inappropriate roles.

Comments focused mostly around clerical duties such as paperwork and computer inputting, meetings with local GP's and midwifery supervisors to explain and discuss the role of the independent midwife, and publicity activities.

One midwife commented on the problems she had with running an independent practice:

"Travelling long distances is a difficulty. Publicity and marketing, this is crucial to my ability to practice independently but it is not an appropriate activity for a

midwife. I would prefer to be working with local women whose care is paid for by the NHS."

Independent midwives were more confident than NHS midwives to provide information on social and welfare issues, to meet the needs of women from a range of cultural backgrounds and they were also more likely to report that they provided women with social support($p \leq .03$).

Midwives were asked whether any of the following prevented them from carrying out the full range of activities for which they are trained.

Independent midwives were less likely to consider insufficient time, the attitude of consumers, a lack of rotation opportunities and a lack of research skills barriers to practise($p \leq .05$). However, they were more likely to consider local policy and procedure to be a barrier($p = .03$). Independent midwives also identified less factors that prevented them from facilitating women's choices than the NHS sample. Independent midwives were more likely to consider local policy and procedures a barrier to their practise because they had to negotiate access to services and facilities at local level which often were not easily accessible.

Independent midwives were more likely to indicate that midwives need to be autonomous, nurturant, creative, analytical and independent($p \leq .04$). They were less likely to consider midwives need to be a good team worker, respectful of authority, authoritative or dressed in uniform($p \leq .03$).

Aspects of care provided by independent midwives

Independent midwives generally provided care within a wider framework than the NHS sample, but were more similar to NHS community and 'integrated' midwives than hospital midwives. They were less involved in providing technical aspects of care than NHS midwives.

7.4 Education and Training Needs of Independent Midwives

Midwives were asked whether they considered they personally required continuing education or training.

Independent midwives identified similar education and training needs to the NHS sample, namely, research, clinical skills and counselling skills.

CHAPTER 5: RESULTS FROM COMPARISONS BETWEEN THE PROFESSIONAL GROUPS (Questionnaire)

The total number of respondents in each of the professional groups was:

Midwives (n=771), Supervisors (n=172), Consultants (n=119), Registrars (n=91) and General Practitioners (n=164). Response rates were: Midwives: 70%, Supervisors: 83%, Consultants: 58%, Registrars: 46%, GP's: 65%.

Results have been presented in 3 sections:

SECTION 1 **SUPERVISORS, MIDWIVES, DOCTORS**

SECTION 2 **SUPERVISORS AND MIDWIVES**

SECTION 3 **INFORMATION FROM PROFESSIONALS WORKING IN THE SAME UNIT**

Most of the information has been presented in graphical format for ease of understanding. (The significance levels reported below in Figures 5.1 to 5.16 indicate that these levels of significance were reached for each of the analyses undertaken (i.e. there were differences between the professional groups). Where a significance level has not been reported beneath a chart, it should be assumed that there were no significant differences between the professional groups.

SECTION 1 SUPERVISORS, MIDWIVES, DOCTORS

1.1 MATERNITY SERVICE PROVISION

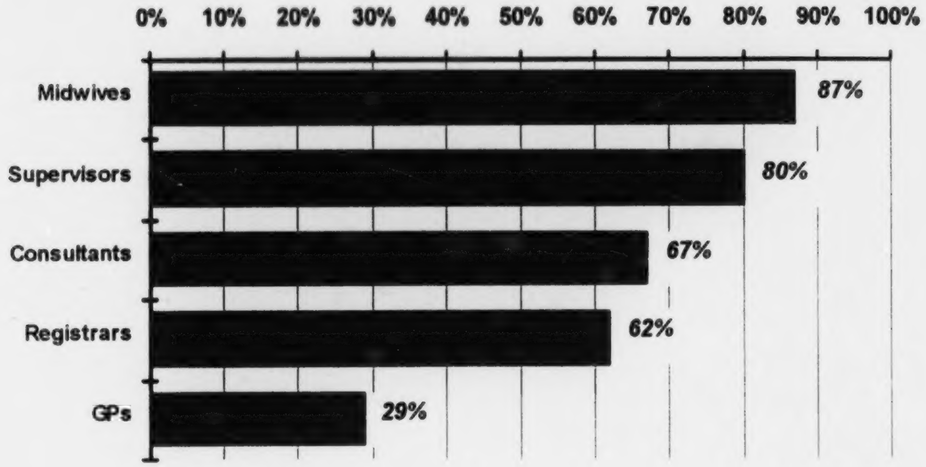
1.1.1 The Lead Professional

Each professional group was asked, with regard to low risk women :

(i) which professional group do you consider should provide a substantial part of the care personally and be responsible for ensuring women have access to care from other professionals as appropriate: (a) antenatally, (b) during labour and delivery and (c) postnatally.

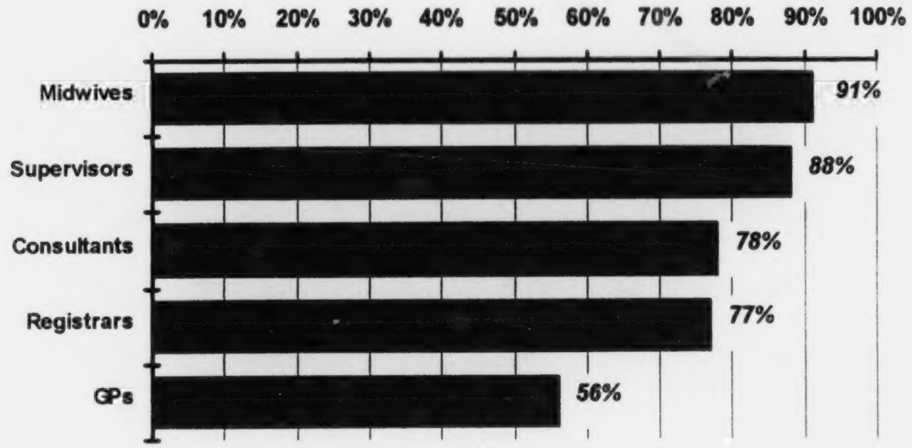
The bar charts below show the percentages of professionals who considered that the midwife should be the lead professional.

Figure 5.1: Midwife the lead professional for low risk women (antenatally)



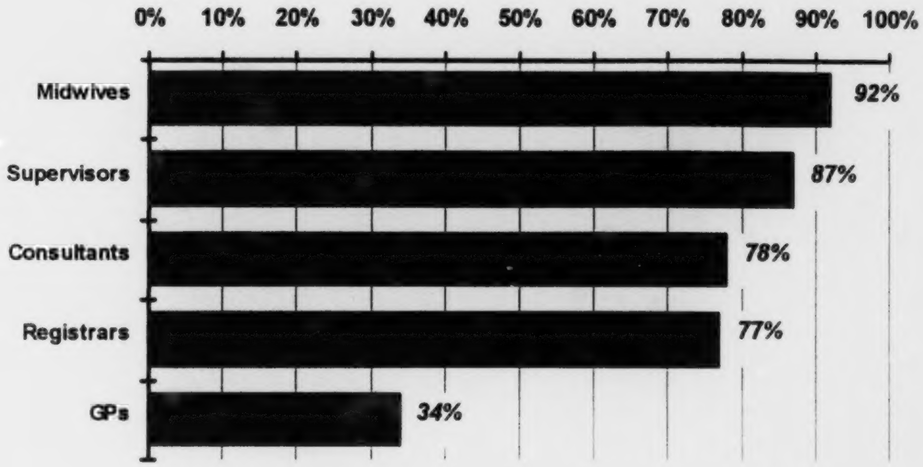
(p<.00001)

Figure 5.2: Midwife the lead professional for low risk women (during labour and delivery)



(p<.00001)

Figure 5.3: Midwife the lead professional for low risk women (postnatally)



(p<.00001)

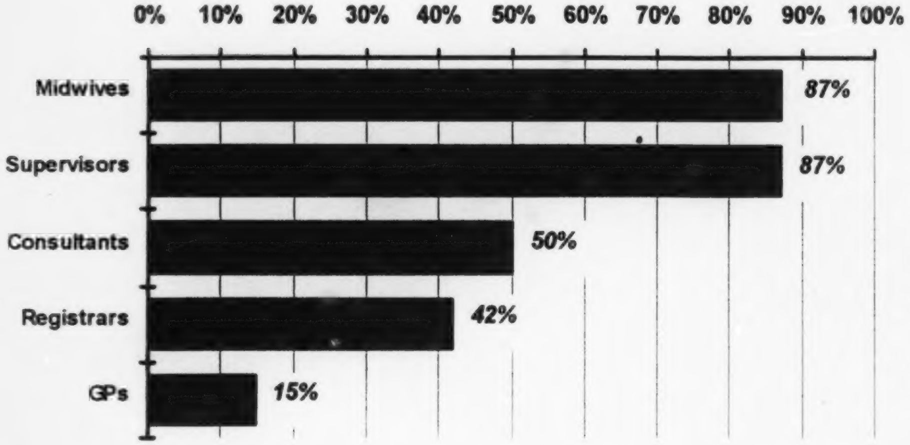
It is particular noteworthy that GP's were by far the least likely to consider midwives should undertake the lead professional role, particularly in the antenatal and postnatal periods, where joint responsibility between the midwives and the GP was the most frequently mentioned option.

The respondents were also asked: with regard to low risk women:

(ii) Which professional group do you consider should carry overall responsibility for women with low risk pregnancies: (a) antenatally, (b) during labour and delivery and (c) postnatally.

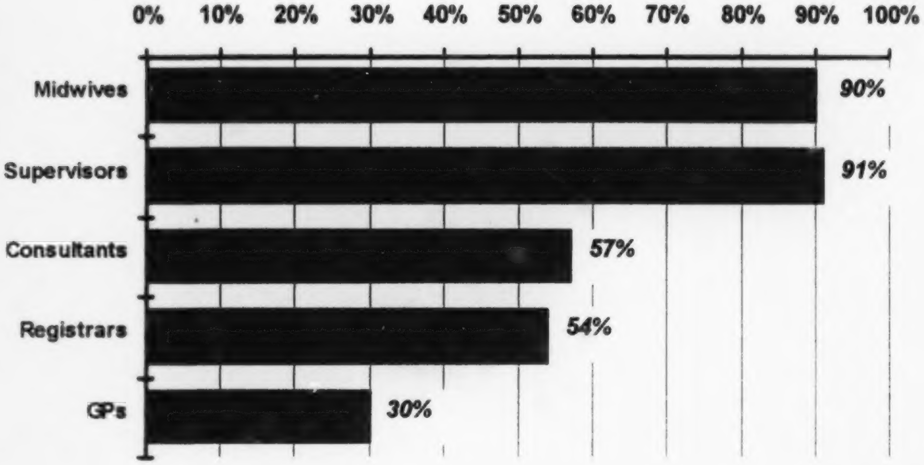
Figures 5.4 to 5.6 below indicate the percentage from each group who considered the midwife should undertake this role.

Figure 5.4: Midwife carry overall responsibility for care of low risk women (antenatally)



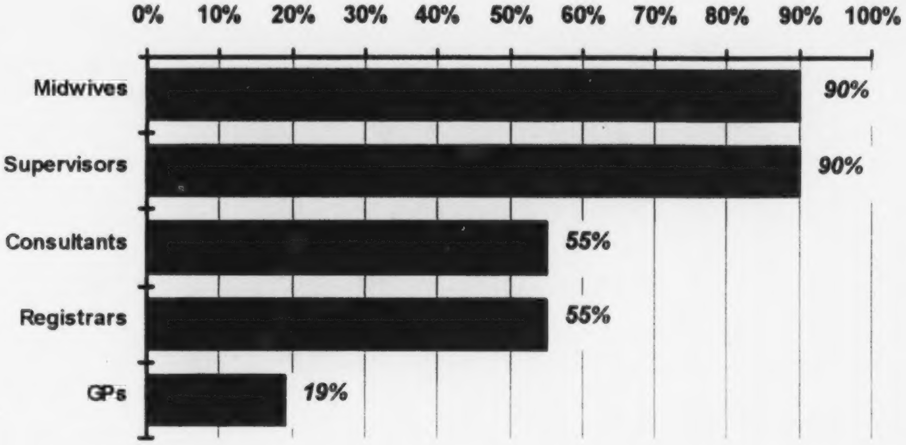
(p<.00001)

Figure 5.5: Midwife carry overall responsibility for care of low risk women (during labour and delivery)



(p<.00001)

Figure 5.6: Midwife carry overall responsibility for care of low risk women (postnatally)



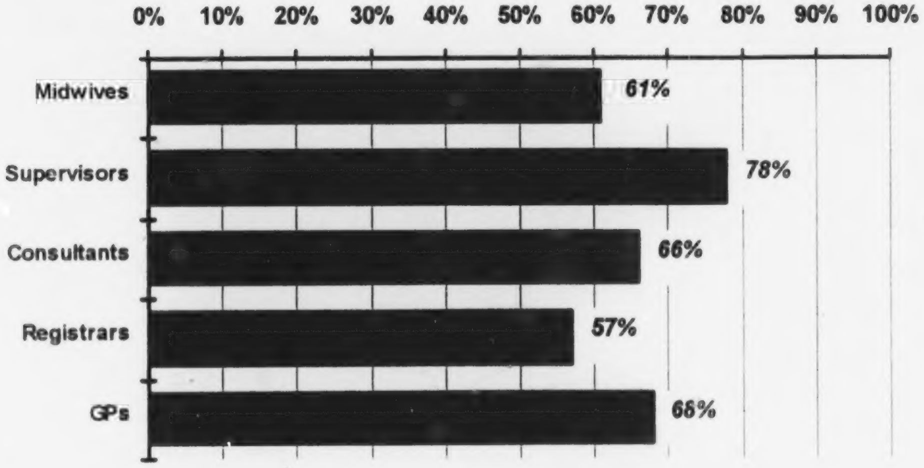
(p<.00001)

Midwives and supervisors were more likely than medical staff to consider that midwives should carry overall responsibility for care.

1.1.2 Implementation Of Changing Childbirth

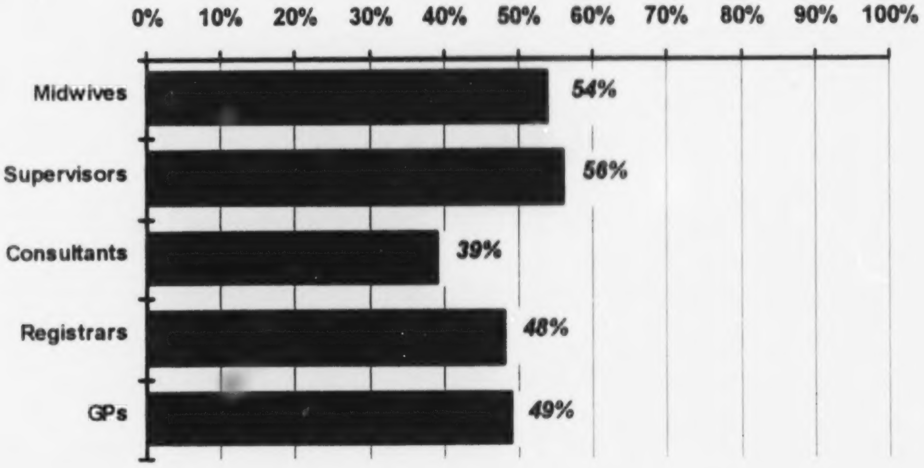
Professionals were asked to indicate whether 7 of the Changing Childbirth indicators of success had been implemented in their service. The indicators are those most directly relevant to midwifery practice. In addition, professionals were asked whether women were fully informed concerning their care, and whether women had a full range of choice regarding the place of birth. Although these were not specifically indicators of success outlined in Changing Childbirth, they were key concepts throughout the report. The results reported in the figures below indicate the percentage of professionals who reported that the practices were occurring in the units in which they worked/worked with.

Figure 5.7: Do all women have a named midwife?



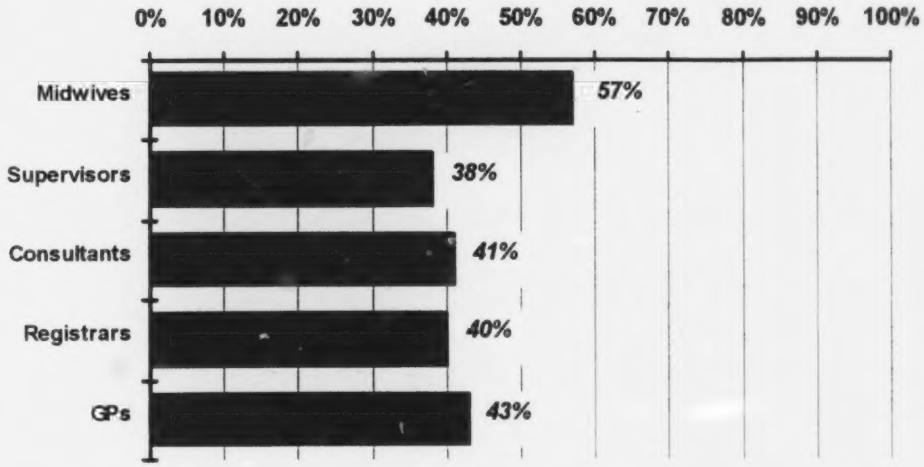
(p=.0002)

Figure 5.8: Do midwives have direct access to some of the beds in all your maternity units?



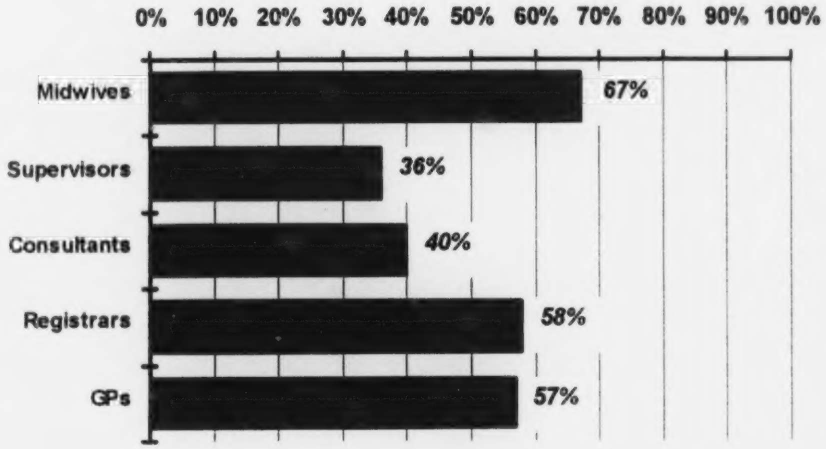
(p=.04)

Figure 5.9: Are at least 30% of women admitted to maternity units under management of a midwife?



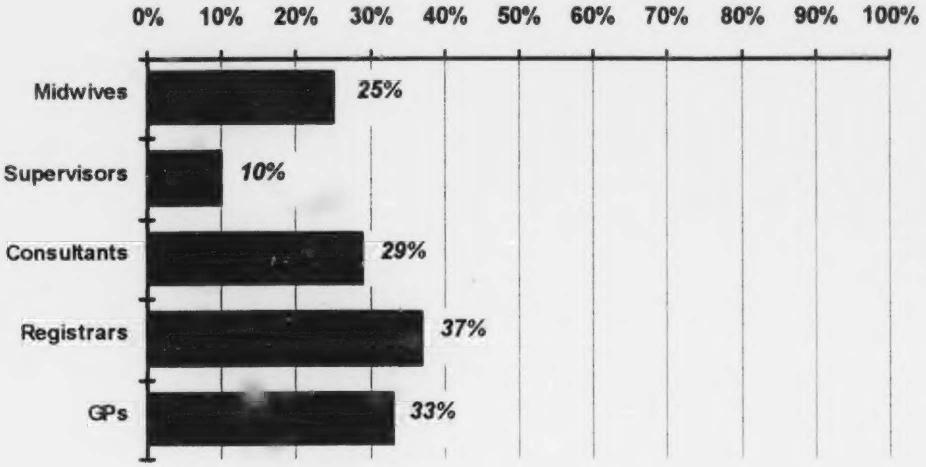
(p<.00001)

Figure 5.10: Is a midwife the lead professional for low risk women in 30% or more of cases?



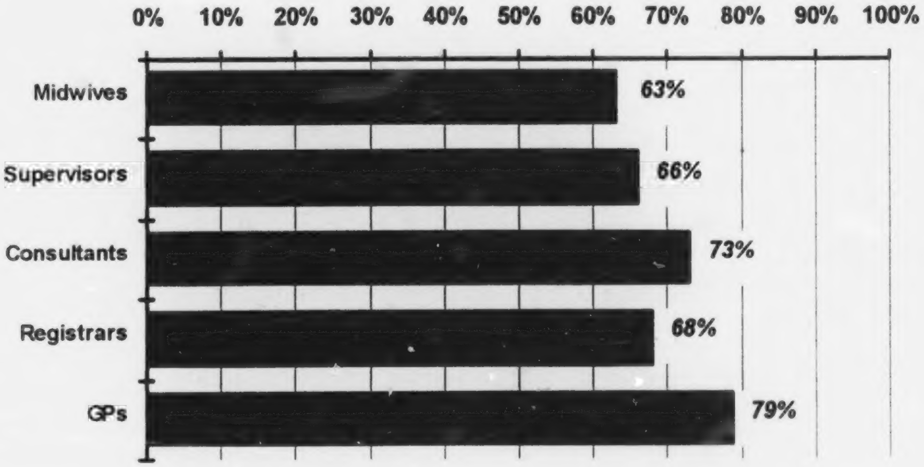
(p<.00001)

Figure 5.11: Do at least 75% of women know the person who cares for them during their delivery?



(p<.00001)

Figure 5.12: Are all women entitled to carry their own notes?



(p=.0007)

Figure 5.13: Do all women know who their lead professional is?

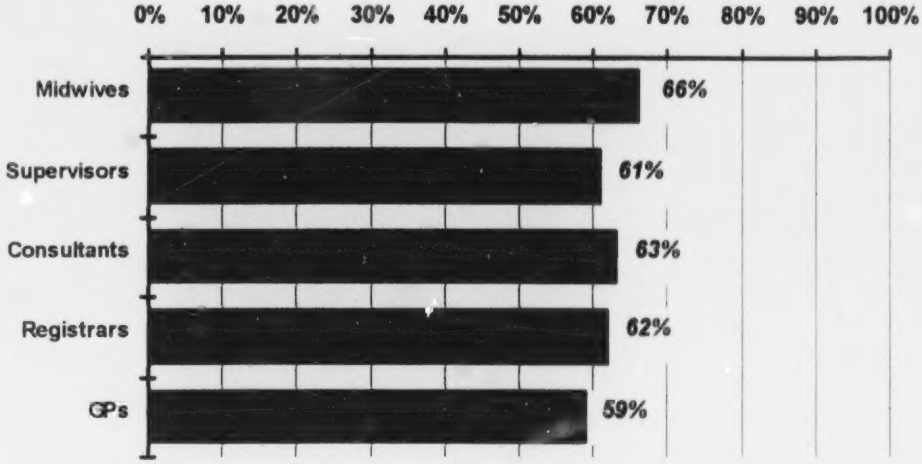


Figure 5.14: Do all women have the full range of choice regarding place of birth?

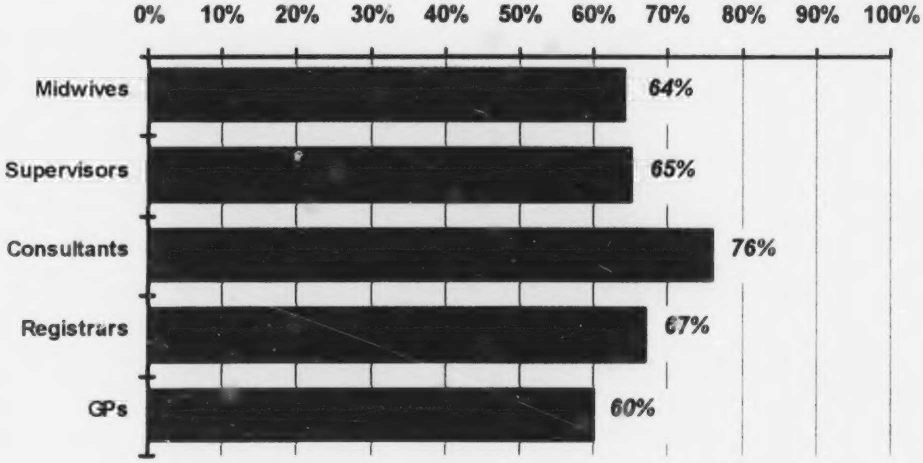


Figure 5.15: Are all women fully informed concerning their care?

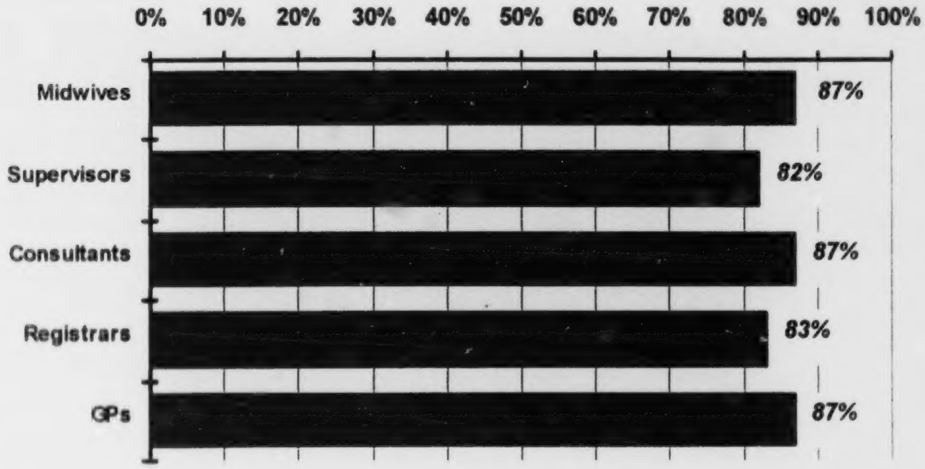
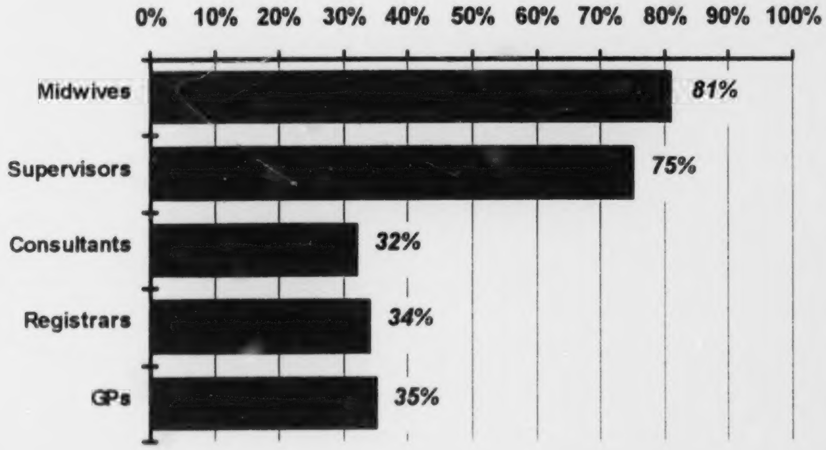


Figure 5.16: Do you consider the implementation of Changing Childbirth indicators of success will improve the quality of maternity services?



(p<.00001)

As can be seen from the figures presented above, there was considerable variation between the professional groups concerning the extent to which they reported that Changing Childbirth was being implemented. It may be of particular interest to note that midwives were most likely to report that at least 30% of women were admitted under the management of a midwife, and that a midwife was the lead professional for low risk women in 30% or more of cases. Doctors were less likely than midwives or supervisors to consider that the implementation of Changing Childbirth would improve the quality of maternity services. A further interesting point arises in relation to the extent to which professionals working in the same unit reported that Changing Childbirth was being implemented. Further findings regarding this issue have been reported in Section 3.

CHANGING CHILDBIRTH

If the practices outlined in Figures 5.7 to 5.16 were not occurring in the maternity unit in which professionals worked they were asked to comment.

Do all women carry their own notes?

The majority of midwives, supervisors, GP's, consultants and registrars reported that women carried their own notes. Over half of those who commented indicated that plans were being made for women to carry their own notes in the future. Nearly all the GP's indicated that this already occurred. A minority of midwives, supervisors and registrars commented that some consultants would not permit women to carry their own notes. Almost a fifth of consultants considered that it was not a good idea for women to carry their own notes as they would get lost and shabby. A small number of midwives reported that women had carried their notes in the past but had lost them or forgotten to bring them to antenatal appointments.

Do all women have a named midwife?

The majority of midwives, supervisors, GP's, consultants and registrars reported all women had a named midwife. Where this was not currently in operation, plans were being made in the majority of units for implementation in the near future, either on an individual basis or through a team approach. This concept operated in many different ways. More information on the named midwife has been provided under the section dealing with continuity of care issues (Section 2: 2.1.2). Doctors frequently indicated that having a named midwife or lead professional may not necessarily lead to an improvement in the quality of the service provided.

A minority of consultants and registrars raised concerns about the practicalities of this concept. In particular, they commented on the problems of implementing such a system when midwives worked shifts. They considered that disruption was more likely to occur to care if the named midwife system was implemented under current working arrangements. Similarly a number of comments were made by midwives in relation to difficulties they would have providing continuity of care. The following two quotes are typical of the comments received:

"There are many midwives who cannot work flexible shifts and be on call who none the less are very skilled and professional" (midwife).

"I tried a caseload but unfortunately I was told by my midwifery manager that I could not continue looking after my patient who I had cared for up to the 34th week of pregnancy. The reason being I was a 'G' grade and there would be no cover for the unit if the lady went into labour at an inappropriate time!" (midwife).

Are all women fully informed concerning their care?

The majority of midwives, supervisors, GP's, consultants and registrars reported that all women were fully informed concerning their care.

Less than a quarter of the midwives reported that women were not fully informed. Some examples given were that there may be language difficulties which affect communication, some mothers are not interested, particularly those from low socio-economic groups, and some mothers are not assertive enough to ask for information. Some midwives indicated that their caseloads were too large for them to give full information to all women. A small number of midwives also commented that the communication skills of the midwife played an important part in information giving to women. One in ten midwives indicated that the medical profession do not inform women.

One midwife identified when potential conflict may arise:

"I offer mothers unbiased opinions. I give them the freedom to choose as long as I consider it safe for mother and child".

Approximately a quarter of GP's commented that information giving to women could be better. A quarter of the consultants and nearly a fifth of registrars questioned the terminology *'fully informed'*, e.g. What is it? Is anyone fully informed, even doctors. How much information? Do women really want to, or indeed understand, even when they are provided with information?

Is a midwife the lead professional for low risk women in 30% or more cases?

More than half the midwives, GP's and registrars indicated that this occurred., whereas just over a third of supervisors and consultants reported this to be the case. Around two thirds of the supervisors, one third of the midwives and GP's, 40% of the consultants and a quarter of the registrars commented. Approximately a third of the comments from midwives and supervisors indicated that there were plans to introduce and/or pilot the above indicator. Nearly half the comments from GP's indicated that this role was shared between themselves and the midwives. A small number of GP's indicated that care provision was supposed to be a team effort, with one commenting:

"I don't think it matters who is the 'lead' professional as long as we all work together and co-operate with the patients best interest at heart and trust each other, otherwise there will be a disaster who ever is 'leading'.

Of the consultants who commented, a third reported that implementation was currently being planned or was under discussion. A minority of consultants considered they were the lead professional. One consultant called the midwife being the lead professional: *"a ridiculous proposition."*

Nearly half the registrars who commented reported that the midwife was not the lead professional, with almost a third indicating that they did not know if the midwife was the lead professional in 30% or more of cases. One registrar commented that:

"Midwives are not trained to lead as they cannot accept responsibility".

Do women know who their lead professional is?

More than half the midwives, supervisors, GP's, consultants and registrars indicated that women knew who their lead professional was.

Nearly a quarter of the midwives and almost a fifth of supervisors considered that women think the consultant or GP is their lead professional.

Approximately a third of supervisors reported that the mechanisms for achieving the indicator were being reviewed with one in five indicating that it had been achieved to some extent.

A small number of midwives reported that women knew who their lead professional was on a daily basis i.e. the person who dealt with them on that day.

Do at least 75% of women know the person who cares for them during their delivery?

Approximately a third of the GP's and consultants and forty percent of the registrars considered that the above indicator had been achieved, with only a quarter of the midwives reporting that this was the case. Only one in ten supervisors indicated that this occurred in their maternity service.

More than three quarters of the supervisors, approximately two thirds of the midwives, half the consultants and registrars and 40% of the GP's commented. Of the midwives who commented, the majority reported that invariably the mother met the midwife who cared for her during her delivery for the first time when she was in labour. Approximately half the GP's, consultants and registrars, and a fifth of supervisors made similar comments to those made by the midwives. Several reasons were given by all the professions as to why women did not know the person who cared for them at delivery, these included: the maternity unit was too large, with insufficient midwives, the midwives shift system was not conducive to such a practice and teams were too large to enable women to know all team members. Nearly half the GP's indicated that the mother may have met the midwife who delivered her on a previous hospital visit, but they were not really sure.

Approximately one in ten midwives, supervisors and GP's considered that if the woman had a home birth, domino delivery, community midwife delivery, gave birth in a GP unit or was cared for by a small team of midwives, it was very likely that she would know the midwife who cared for her.

Approximately half the supervisors, indicated that there were plans to either implement or pilot this concept in the future. Some midwives reported that hospital midwives were starting to visit GP antenatal clinics to facilitate this process.

A fairly small number of professionals questioned the terminology 'to know'. Some consultants commented that the terminology 'to know' was vague, whilst one commented '*you must be joking*'. One registrar considered that the midwife may not know the woman *'on admission but hopefully by delivery'*. A number of midwives stated that mothers have reported in surveys that it is not essential to know the midwife before delivery, as long as she was kind and caring.

Do midwives have direct access to some of the beds in all your maternity units?

Approximately half the midwives, supervisors, GP's and registrars indicated that midwives had direct access to some of the beds, whereas, around forty percent of consultants considered this to be so. Less than half of each of the professional groups commented. Of those who commented, over a third of midwives indicated they did not have direct access to beds, reasons for this included: admission could only be made with medical involvement, there were only 'consultant' beds, and it had been discussed and turned down by GP's. Just under half the registrars and consultants reported that midwives do not have direct access to beds, the reason given by several registrars was that medical staff take responsibility and admissions were discussed with them. Similarly one consultant commented that midwives *'rely on consultants in several ways'*, another indicated that "*patients have access to beds, rather than doctors or midwives*"'.

A minority of the supervisors reported that midwives only had direct access to beds for women who were in labour. Some midwives commented that access was available for domino and community deliveries, for low risk women, if the woman was cared for in a GP unit, or through a GP scheme, or being cared for by an independent midwife.

A small number of supervisors considered there was resistance from the medical staff. One supervisor commented that the decision regarding this indicator would be taken in conjunction with the consumers, and one reported that the indicator was *'not in the spirit of Changing Childbirth'*.

Are at least 30% of women admitted to maternity units under the management of a midwife?

Over half the midwives reported that at least 30% of women were admitted to maternity units under the management of a midwife. However, less than half the supervisors, GP's, consultants and registrars indicated that this had been implemented. Approximately two thirds of the supervisors, one third of the midwives, 40% of the consultants and registrars and a quarter of the GP's commented. Of those who commented, approximately a third of midwives, supervisors, GP's and registrars considered that the midwives generally manage the women but that the responsibility remained with the medical staff. Almost half the registrars commented that the above indicator had not been achieved. A third of GP's indicated that they did not know or were not sure if 30% of women were admitted to maternity units under the management of a midwife. One GP reported that *'I thought all maternity units are managed by midwives'* whilst another commented: *'No, God help us'*

Approximately half the supervisors reported that discussions were in progress to achieve the indicator.

Do all women have the full range of choice regarding place of birth?

More than 60% of all the professionals reported that women had the full range of choice regarding the place of birth. However, of the GP's who commented (a third of the sample), the majority indicated that their practice did not offer home births, with one GP commenting that *'I feel we tend to lead women to the place we as professionals favour'*. The majority of consultants and approximately a quarter of midwives, supervisors and registrars who commented, reported that GP's did not encourage home births.

A small number of midwives considered that women would have more choice if they were seen by the midwife first, and nearly a fifth indicated that the GP made the decision for the woman regarding where she gave birth.

However, all the professional groups cited some problems with offering women full choice. These included insufficient resources to provide a range of options, such as closure of GP units, no pool available for labour and delivery in water, and staff shortages. Other reasons mentioned included geographical factors (e.g. rural nature of area with large distances to travel), language barriers and women not being given full information.

Do you consider the implementation of the above 'indicators of success' will improve the quality of maternity services?

Approximately three quarters of the midwives and supervisors, and a third of the GP's, consultants and registrars considered that the implementation of Changing Childbirth would improve the quality of maternity services.

Comments regarding this issue were very broad. Approximately a third of the supervisors, 20% of the midwives, a third of the GP's, half the registrars and sixty percent of the consultants commented. Of the midwives and supervisors who commented, nearly half indicated concern regarding resourcing issues. These generally focused around staffing issues, whereby there may be insufficient midwives available to achieve the targets. Midwives were also concerned about the effects that implementation would have on staff, such as burnout, stress and decreased morale. Some supervisors considered that midwives were not prepared for Changing Childbirth. For example, one supervisor reported that some midwives were not prepared for the commitment involved, and another that some midwives were not able to carry the responsibility because of the commitment required.

All the professions commented to some extent about evaluation of the indicators of success, with the medical professionals making most of the comments. Doctors were most likely to indicate that the indicators were not based on research and had not been evaluated. Almost 20% of the supervisors, and approximately one in ten midwives also indicated the necessity for the indicators to be thoroughly 'audited and evaluated.' One supervisor commented that:

"Evaluation of the above indicators of success will identify if the consumer considers that the quality of maternity services has improved. Indeed how many may care if it improves, apart from radical consumer groups" .

Another commented:

"Quality of care and patient satisfaction are two different issues. I have known women who have poor care but are very happy with the care they have received".

A third of the registrars considered that midwives may not be capable of taking full responsibility for women particularly antenatally and during the intrapartum stage. They indicated that safety was very important and that things could go wrong very quickly causing a deterioration in the quality of care provided. One in ten consultants considered that midwives were not willing to take on the responsibility of being on call for 24 hours. A number of GP's were concerned about home births, and in particular that some doctors and midwives would not be competent to deal with emergencies that occurred e.g. resuscitation of the infant and post postpartum haemorrhage. Further education for midwives was considered important by one in ten consultants and registrars, with a small number of midwives indicating that there were implications for their education, whereby some may need more skills, and some to have their experience updated in different settings.

Approximately 10% of midwives and supervisors reported that women were not worried about knowing the midwife who delivered them, and that it was more important for the midwife to be caring, supportive and helpful.

A small number of midwives were concerned that medical staff would not allow them to give all the care to low risk women, and that the GP's were not keen on home births. Conversely, one in ten GP's indicated their concern that they may be excluded from maternity care. With one GP commenting:

"I feel the implementation of some of the government's proposals as interpreted by midwife managers, may destroy the team basis of General Practitioner maternity care in our practice" .

and another stated:

"I believe if pregnant women only see a midwife... care will be substandard. We believe in the Primary Health Care Team!".

The need to ensure that all women's needs were met was identified on several occasions and the following quotes exemplify some of the thinking:

"I feel that a lot of notice has been taken of the desires of the local middle class mothers and not of a cross section of society. Most women have difficulty even naming their own GP, let alone a number of other professionals". (midwife)

"The service will improve for the social classes who seem to demand their rights irrespective of scarce resources. More resources must be given to the deprived and needy. Everyone should have equality in care in the NHS" .(midwife)

1.2 ASPECTS OF CARE PROVIDED BY MIDWIVES

The majority of supervisors indicated that either all or some of the midwives in their units provided a wide range of aspects of care, including:

monitoring normal pregnancy; advising on examination for earliest diagnosis of pregnancy at risk; providing parenthood education antenatally; providing full antenatal care autonomously to low risk women; providing care for mothers during labour; conducting spontaneous deliveries in hospital and at home; conducting a breech delivery in an emergency; providing alternative methods of pain relief and deliveries in alternative positions; recognising the need for medical assistance;

taking emergency measures in absence of a doctor; carrying out the treatment prescribed by a doctor; assisting with a caesarean section; examining and caring for the newborn; caring for the mother postnatally in hospital and at home; providing total care to low risk women; advising mother on infant care; maintaining all necessary records; advising on family planning and providing lifestyle advice.

Consultants and registrars were also generally in broad agreement with the supervisors in relation to the involvement of midwives in specific aspects of care.

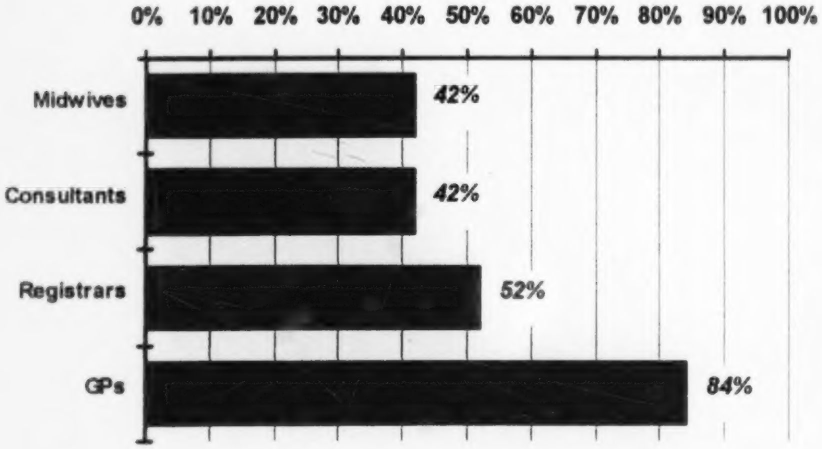
General Practitioners were often in agreement with the other professional groups although they were less likely to indicate that midwives provided medical aspects of care in the absence of a doctor, which may reflect their relative lack of contact with midwives in such situations.

The majority of midwives also indicated that they personally provided most of the above aspects of care. However, the majority of the sample did not advise on examination for earliest diagnosis of pregnancy at risk, provide full antenatal care to low risk women, or conduct spontaneous deliveries at home. Approximately half of the midwives reported that they provided total care to low risk women.

The figures below outline the findings regarding the provision of certain aspects of care when the findings were not consistent with the general pattern discussed above.

The extent to which midwives provide full antenatal care autonomously to low risk women.

Figure 5.17: Provision of full antenatal care autonomously to low risk women



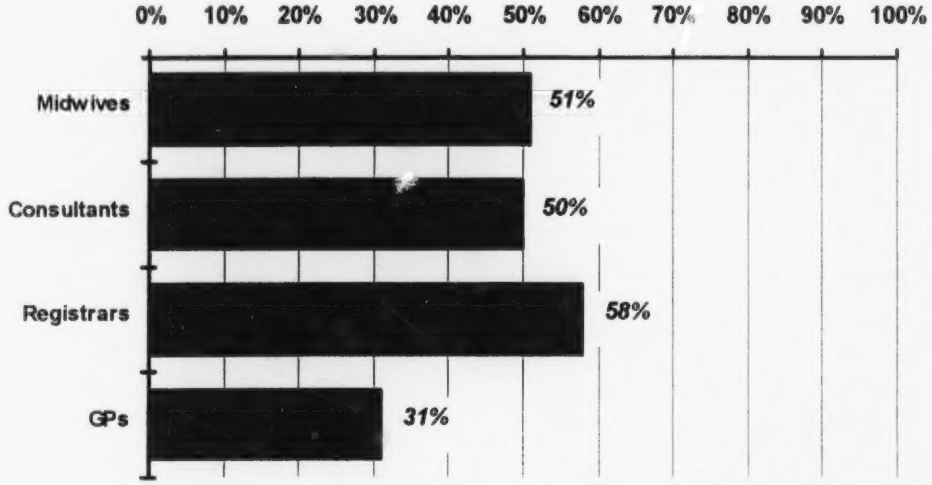
(p<.00001)

Supervisors results have not been included in the above analyses because the question was worded differently in order to obtain a broader perspective on the situation occurring within units.

These findings may reflect the fact that it is more likely to be community/ 'integrated' midwives who provide full antenatal care autonomously to low risk women than those based in hospital($p<.00001$). These midwives are more likely to work closely with GP's. Sixty six percent of community and 'integrated' midwives indicated they provided this aspect of care - which is still lower than the percentage indicated by GP's. Different perceptions regarding the definition of this type of care may arise (see Chapter 8 for further discussion).

The extent to which midwives provide total care to low risk women.

Figure 5.18: Providing total care to low risk women



($p=.00001$)

General Practitioners were least likely to consider midwives provided total care to low risk women. Sixty six percent of community and 72% of 'integrated' midwives indicated that they provided total care in this respect. Again, different definitions of the term may be being used. In response to other questions, GP's indicated that midwives normally did not provide intrapartum care to most of the women they cared for. Therefore, this may have led them to consider that midwives do not provide total care to low risk women (see Chapter 8 for further discussion of these issues).

1.2.1 Involvement Of Midwives In Providing 'Enhanced Role' Activities.

The majority of supervisors indicated that some or all midwives provided the following aspects of care:

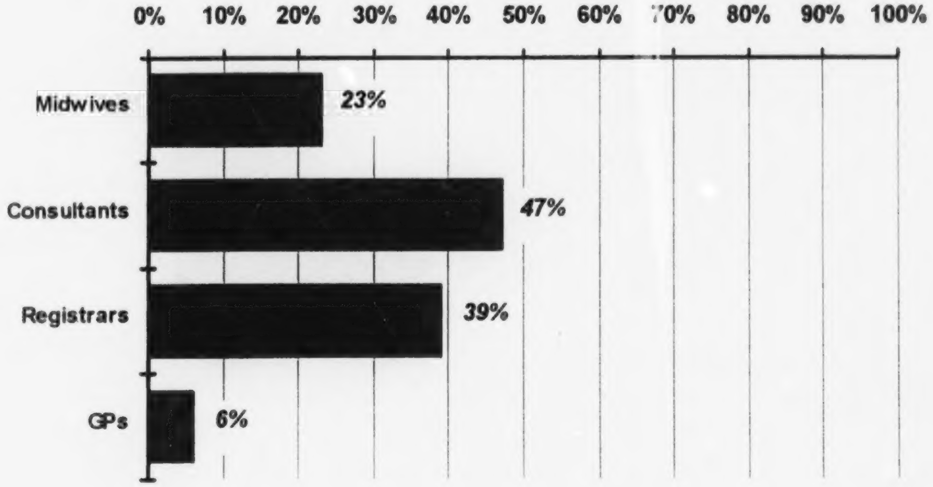
IV cannulation, epidural top ups, perineal suturing, application of fetal scalp electrodes, interpretation of CTG's and labour and delivery in water. However, under half the sample indicated that midwives were involved in ultrasonography.

The majority of midwives also indicated that they provided the following aspects of care: *epidural top ups, perineal suturing, application of fetal scalp electrodes and interpretation of CTG's.* Approximately half the sample of midwives indicated they provided care in relation to labour in water. A minority reported that they were involved in the following areas: *IV cannulation, ultrasonography, and labour and delivery in water.*

Consultants and registrars views were generally consistent with those of the midwives. General Practitioners were least likely to indicate midwives were involved in 'enhanced' role activities.

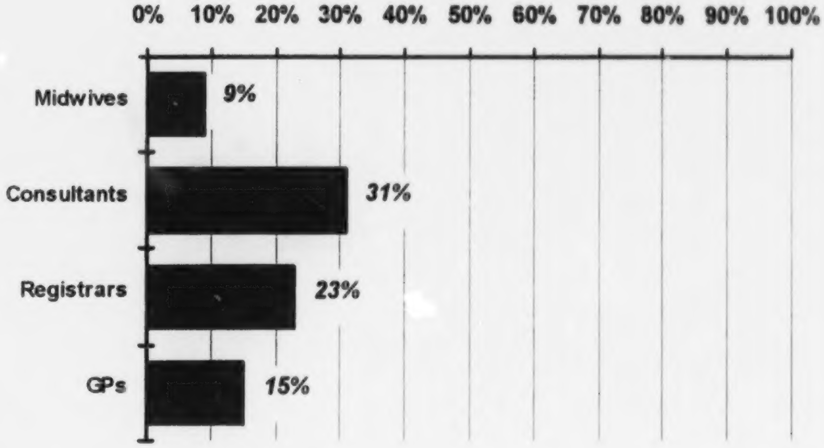
The graphs below show some interesting findings which do not necessarily fit in with the general pattern outlined above.

Figure 5.19: Involvement of midwives in IV cannulation



(p<.00001)

Figure 5.20: Involvement of midwives in ultrasonography



(p<.00001)

Hospital doctors were most likely to report midwife involvement in IV cannulation and ultrasonography.

1.2.2 Midwives Involvement In Counselling Activities

The majority of supervisors indicated that all or some midwives provided counselling in the following areas: *HIV/AIDS, bereavement, preconceptually, in relation to antenatal screening for complicated pregnancies, for complicated deliveries, in the puerperium, general counselling and counselling in relation to smoking cessation.* The majority of midwives also reported that they provided counselling in the majority of these areas. Around half the sample reported involvement in counselling in relation to complicated pregnancies and smoking cessation. A minority reported involvement in preconceptual counselling, and for HIV/AIDS.

Consultants and registrars, and interestingly GP's, were generally more likely to indicate midwife involvement in a broad range of counselling activities than midwives.

1.2.3 Addressing the needs of women from a range of backgrounds

Approximately two thirds of the supervisors, half the GP's and one third of the consultants and registrars considered that all midwives addressed the needs of women from a range of social backgrounds. Approximately a third of the doctors and half of the supervisors considered that all midwives addressed the needs of women from a range of cultural backgrounds.

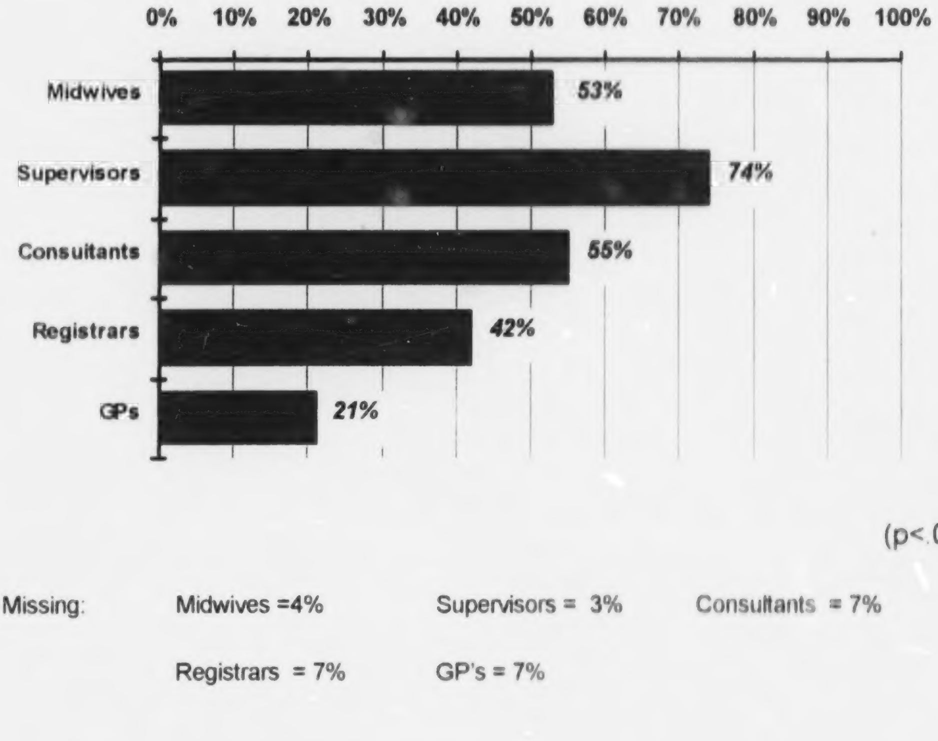
Over half of the supervisors and consultants, a third of the registrars and approximately a quarter of the GP's, commented in relation to midwives' competence to identify and meet the needs of women from a range of social and cultural backgrounds. Comments generally related to the importance of an individual's personal experience, knowledge and interest. Approximately half the supervisors who commented identified the need for further education in this area, particularly for the newly qualified midwives. A further third indicated that there was no need to address such issues as there were so few women from ethnic backgrounds living in the locality. The following comment from a GP indicates the general tenor of the comments made:

"I would expect all doctors and midwives to be socially and culturally aware but the nature of life is that we are not totally aware of the cultural and religious needs of other communities"

1.2.4 Overlap between midwives and doctors.

Each professional group was asked whether there are any areas of unnecessary overlap between midwives and doctors.

Figure 5.21: Overlap between midwives and doctors



(p<.00001)

Missing: Midwives =4% Supervisors = 3% Consultants = 7%

Registrars = 7% GP's = 7%

Approximately half of the midwives and consultants, three quarters of the supervisors, forty percent of the registrars and a quarter of the GP's commented in relation to unnecessary overlap between midwives and doctors.

The main area of unnecessary overlap identified by midwives and supervisors related to the involvement of doctors with low risk women, particularly in hospital on the delivery suite, and in the antenatal period. One midwife commented:

"there are times when women are subjected to unnecessary vaginal examinations because doctors do not always show confidence in the midwives findings".

Unnecessary duplication was considered to occur antenatally both in relation to hospital doctors who duplicated work in clinics, including booking women after the midwife had already completed the procedure, and GP's who often insisted on seeing women at least at every other visit. As one midwife put it:

Some GP's are unfortunately archaic in their beliefs and would not hand over or trust us to give total care to low risk women".

Other areas where midwives and supervisors identified the potential for overlap included hospital doctors checking midwives work, such as the siting of IV cannulas.

A small number of supervisors indicated that routine postnatal home visits by GP's following mothers transfer home from hospital was unnecessary.

Comments made by GP's often reflected the importance of some "overlap" between professional roles, which was seen as necessary to ensure a quality service and in particular to enhance continuity and safety.

The following comments from GP's were typical of the views expressed:

"I don't understand this question, in our practice we share our work equally ".

"Some overlap should be desired and deliberate in the interests of patient safety".

Approximately half of the consultants who commented considered that overlap occurred in all areas of care for 'low risk' women, where midwives often acted as handmaidens to doctors, particularly in antenatal clinics. The need for a certain amount of duplication was identified by a small number of the consultants, in the interests of quality monitoring and well co-ordinated care. However, this was generally considered most important in high risk areas. The main barrier to effective midwifery care was thought to be the lack of motivation of some midwives to equip themselves with the knowledge and skills to deliver quality care.

The majority of registrars who commented considered that there was a need for a certain amount of overlap for safety reasons or because midwives lacked the confidence to provide care without medical support or advice. One registrar commented

"A few grey areas difficult to define. Nothing beats a competent midwife in obstetrics. An incompetent midwife is a disaster! I guess this goes for all professions".

A minority of registrars considered that there was a certain amount of unnecessary overlap between midwives and senior house officers, particularly regarding booking/clerking low risk women.

1.2.5 Perceived competence of midwives to provide care

Supervisors and doctors were asked to comment on any areas in which they considered midwives were not competent to provide care.

Seventy five percent of supervisors, a quarter of consultants and GP's, and forty percent of registrars commented.

Approximately half of the supervisors who commented considered that a lack of education/training and limited opportunities for experience prevented midwives from providing some aspects of care. The lack of education/training was seen to be largely due to financial difficulties in relation to sending midwives on courses, such as to learn IV cannulation techniques, and a lack of facilities to practise skills (e.g. pools for water births).

In particular, the existence of specialist staff in some areas was seen to limit opportunities for the majority of midwives to increase their competence. However, opinions varied and a small number of supervisors did not consider that every midwife should provide care in all areas, such as assisting with caesarean sections, and providing care in enhanced role activity areas, especially ultrasonography. Individual variation in relation to midwives competence to practise, and motivation to develop knowledge and skills was noted frequently.

Individual variation regarding midwives competence and motivation to provide care was also identified frequently by both hospital doctors and GP's. One consultant summed the situation up thus:

"Some midwives are brilliant, some dangerous and some are disinterested".

The majority of comments made by doctors related to the enhanced role activities of midwives, with some differences of opinion apparent. General practitioners and registrars were more likely to consider that midwives needed greater experience in relation to providing such aspects of care, whereas consultants were more likely to raise concerns about the need for 'expert' input into particular aspects of care, such as counselling for HIV/AIDS and ultrasonography. Some registrars obviously considered that midwives should have the skills and experience to provide aspects of care that would help towards the reduction of junior doctors hours. One registrar commented:

"There are too many 'basic skills' like siting IV cannulation, repairing vaginal tears, taking blood and making simple clinical judgements are left to the SHO, instead of midwives with the result of exhausted doctors"

A number of other comments were made by doctors, particularly GP's in relation to midwives having greater involvement in a wide range of high risk situations, including breech deliveries and managing the care of women having a postpartum haemorrhage or miscarriage.

This raises important issues in relation to the midwife as an expert in normal pregnancy and childbirth, and to the potential for involvement in providing aspects of care that may be required in a broad range of high risk situations. It will be important that the potential for confusion and conflict in such situations is minimised in the best interests of all concerned. These issues have been further discussed in Chapter 8.

The potential role of the midwifery management structure in restricting midwives' practice was raised by a minority of GP's, with one commenting:

"Midwives are restrained in their actions and capabilities by the midwife infrastructure in their place of employment".

This is interesting in the light of data reported earlier that indicated that GP's were less likely than any of the other groups studied to consider that midwives should be the lead professional or carry overall responsibility for the maternity care of low risk women. These issues have been discussed further in Chapter 8.

Finally, an important point that was specifically raised by a small number of GP's related to the experience of midwives regarding home births. One GP commented:

"I do not consider a midwife doing 15 home deliveries a year is sufficiently in practice to cope with any problem. If mothers are to have a choice the government must address this problem more responsibly".

Again, the importance of these issues was raised many times during the study, and the issues have been discussed further in Chapter 8.

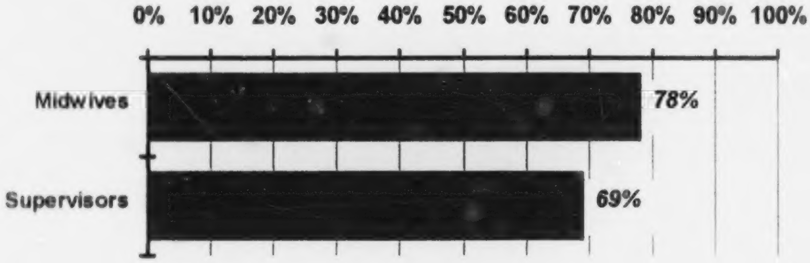
SECTION 2 SUPERVISORS AND MIDWIVES

The findings presented in this section relate to questions that were asked of the supervisor and midwives sample only.

2.1 PROVISION OF MIDWIFERY CARE

2.1.1 Staff rotation system

Figure 5.22: Staff rotation system in operation



(p=.001)

Midwives and supervisors were asked to explain how the rotation system operated.

Sixty eight percent of midwives and seventy eight percent of supervisors commented on how the rotation system operated. Supervisors provided a picture of a much more organised system than midwives, with supervisors indicating that the timescale ranged from about 3 months for E grades through to 18 months for higher grades. Team midwifery, in some form, was identified most frequently by supervisors as the main means through which staff rotation operated. However, a wide range of systems operated in relation to team midwifery, providing midwives with very different experiences countrywide. A minority of supervisors reported that the rotation system was organised to meet the developmental needs of the midwife, and an even smaller number indicated that the system was organised to meet the changing needs of the maternity unit.

The majority of comments from midwives related to the lack of a formal structure in relation to both the system itself, and the time period involved.

In many cases midwives indicated that they expected to work in different settings on a rather 'ad hoc' basis, depending on the staffing situation. Some midwives commented that sometimes they 'rotated on a daily basis'. However, when there was a set time period it generally varied between 3 and 18 months with junior staff tending to have shorter periods of time in each setting.

A variety of rotation systems were apparent, particularly for hospital staff who sometimes rotated between antenatal settings only (clinics and wards), sometimes across antenatal and postnatal settings, and occasionally across antenatal, postnatal and intrapartum care settings. Midwives who provided care in all hospital settings sometimes delivered the baby and provided postnatal care to the same women, sometimes they spent specific periods of time in each setting.

The tendency for staff to rotate between day and night duty was becoming more common.

When community staff worked within a rotation system, it most commonly involved providing all aspects of community care, and hospital based antenatal clinic care. Intrapartum care was rarely provided in a hospital unless through the domino system or a GP unit (neither of which occurred very often).

Some staff in many units undertook a 'core role'. That is they specialised in providing care in a particular setting, or to a particular group of women (e.g. high risk such as those with diabetes), which tended in some cases to lead to a 'them and us' situation developing, with those being instructed by management to work in a variety of settings feeling resentful of core staff.

The main concern about rotation tended to focus around fears of having to provide particular aspects of care when midwives did not feel they got sufficient regular experience to keep up to date with developments, and therefore be competent to provide the care required.

The comments relating to the rotation system pointed to areas of concern rather than potential positive effects. This may be due to the fact that many changes were being implemented as this study was being carried out, leading to a feeling of 'teething' problems.

The following quotes from midwives indicate the tenor of the comments received:

"Staff feel unsettled"

"It is unregimented rotation"

"Very disorganised and often based on who shouts the loudest",

"As a junior grade we are the Jack of all trades and master of none" .

2.1.2 Continuity of care

Ninety two percent of supervisors, sixty six percent of midwives and seventy one percent of GP's commented on the systems in place at local level to ensure continuity of care. Eighty percent of GP's also commented on the ways in which they worked in collaboration with other professionals involved in maternity service provision.

Team midwifery was the most commonly mentioned means for ensuring continuity of care by both midwives and supervisors. However, a wide variety of definitions for team midwifery were given, particularly by midwives. Some midwives indicated that teams of midwives were attached to a particular hospital consultant. The midwives in the team would provide midwifery care to women booked under that consultant. These teams were often large which meant that women did not necessarily see the same midwife/s throughout their care. However, the team worked to ensure that care was based on the same philosophy - although the success of this seemed to vary somewhat. One midwife commented:

"We are experiencing teething problems as each team leader has her own ideas which vary vastly. At present I feel we are giving a disjointed service with less continuity than before".

These teams were predominantly hospital based, and women tended to have another set of midwives for community care.

Around four in ten community midwives worked within a team system, often attached to a particular general practice. Again, teams were of variable size and structure. Some midwives provided all community based care (antenatally and postnatally, with home births occasionally undertaken), whereas others also provided care in hospital-based antenatal clinics. It was rare for community based teams to provide intrapartum care in hospital, unless the woman was being cared for under the domino scheme. However this was becoming more common as more midwives were working in both community and hospital settings. These midwives were usually based within a team. On the whole, community teams seemed to be smaller than hospital-based ones, and women were reported to be more likely to receive a substantial amount of their care from one midwife, with the rest of the care being provided by a small number of her fellow team members.

The named midwife was the second most commonly mentioned system, by both midwives and supervisors, in relation to enhancing continuity. Again, this operated in several ways. Often the named midwife was a community midwife, who was most likely to provide a substantial amount of antenatal and postnatal care. Sometimes the named midwife worked within one of the team systems outlined above.

Numerous methods for operating the named midwife system in hospital were outlined. In some cases a midwife's name was put on the woman's notes, but this midwife was not always available to provide care. Sometimes other members of the same team would be available, but this by no means always happened. In some hospitals only women who had been admitted as in-patients were assigned a named midwife. Often this has been reported to occur on a shift by shift basis, so that the woman would be told who her named midwife was for that particular shift. Sometimes a woman was assigned a named midwife when she arrived at the hospital in labour, and this midwife would also provide postnatal care if it was required during that midwife's shift.

Caseload management (predominantly in the community), midwife only beds, and the domino scheme were also mentioned by both midwives and supervisors as potential means of enhancing continuity of care.

On the whole, more problems were identified in relation to providing continuity of care than potential positive effects, particularly during labour and delivery. These quotes exemplify the types of comments that were most frequently made:

"Continuity takes place only in the community. The midwives are organised into groups so that the women get to know the midwives with coffee mornings etc. There is no continuity of care in the hospital" (midwife)

"Only lip service paid to the term named midwife. On the labour ward the named midwife would look after a woman throughout her shift on that day". (midwife)

"Continuity of care is patchy at present in relation to delivery. However, antenatal and postnatal community care has very high levels of continuity. This has been identified by audit and consumer survey." (supervisor)

"In practice we had a good quality midwifery service before. Since the introduction of teams, continuity in the antenatal period has been reduced to enable women to meet all team members, and yet not guaranteed to be delivered by a "known" person" (supervisor)

On the more positive side two midwives commented:

"In our team we allocate to ourselves the mothers we have seen in antenatal clinics and parentcraft classes, and they are who we deliver". (midwife)

"We have midwifery led antenatal clinics where we give our clients the choice of who they want to see". (midwife)

Finally, it is interesting to note that there was little mention of the use of care plans or birth plans as a means of ensuring continuity of care, nor was the implementation of Changing Childbirth widely identified as having potential in relation to enhancing continuity. A minority of supervisors indicated that they were currently engaged in reviewing options regarding continuity of care.

Many of the comments made by GP's about continuity focused around the links and communication they had with the hospital. Shared care between the GP and consultant obstetrician was the most frequently mentioned means of ensuring continuity, followed by close working relationships between GP's and midwives. A small number of GP's commented on the importance of close liaison between themselves, the midwife and the health visitor. Close liaison through meetings and written communication were the most commonly identified methods through which professionals worked collaboratively.

Specific examples of how continuity was addressed, included women carrying their own notes, having the same GP providing all the care, the same midwife, midwives contacting non clinic attendees and the GP doing the ante and postnatal care themselves. A small number indicated that within their practice a domino scheme was in operation that aimed to ensure continuity for women. A small number also commented that continuity was difficult to ensure as they were a long distance from the hospital and large teams of midwives who work on a rota basis are not conducive to continuity.

The following quotes from GP's exemplify many of the comments received:

"Continuity is non existent except for doctor. Midwife is part-time, therefore difficult to ensure continuity although I don't think there is a solution to this".

"Personally I feel patients can benefit by seeing more than one professional during pregnancy though some degree of continuity is advisable. I personally recommend team continuity rather than individual care".

"I know the patients, however the receptionist knows them better. Women often attempt to confuse the issue by regarding midwifery services and maternity medical care as the same, they are not and are different both by nature and by statute. General Practitioners are under statutory obligations with regard to maternity medical care and whilst midwives are clearly better at normal midwifery, General Practitioners should not devolve responsibility to anyone other than a consultant obstetrician or another General Practitioner as he would be in breach of his service terms".

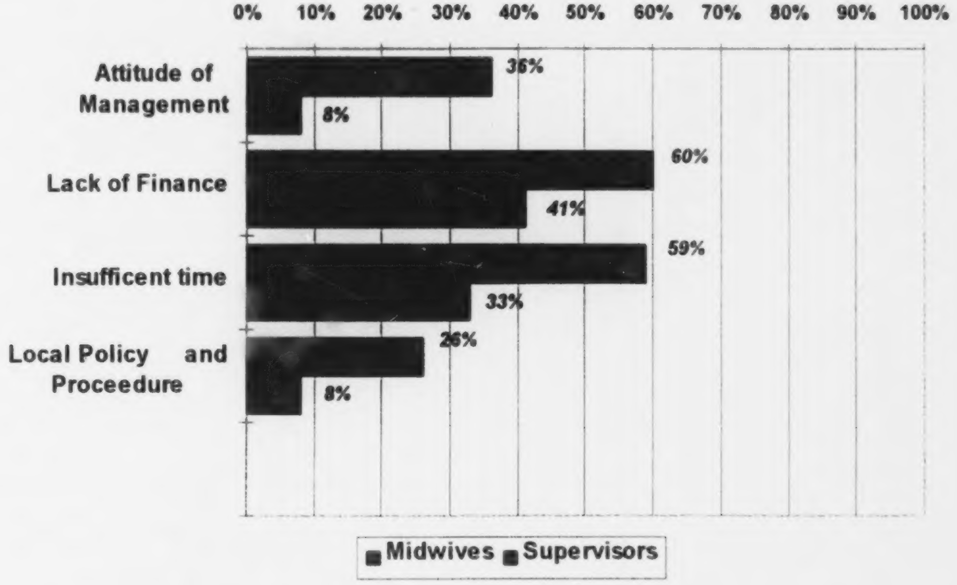
The potential implications of the issues raised in this comment have been discussed further in Chapter 8.

2.2 ROLE AND RESPONSIBILITIES OF MIDWIVES

2.2.1 Factors Preventing Midwives from Undertaking Their Full Role

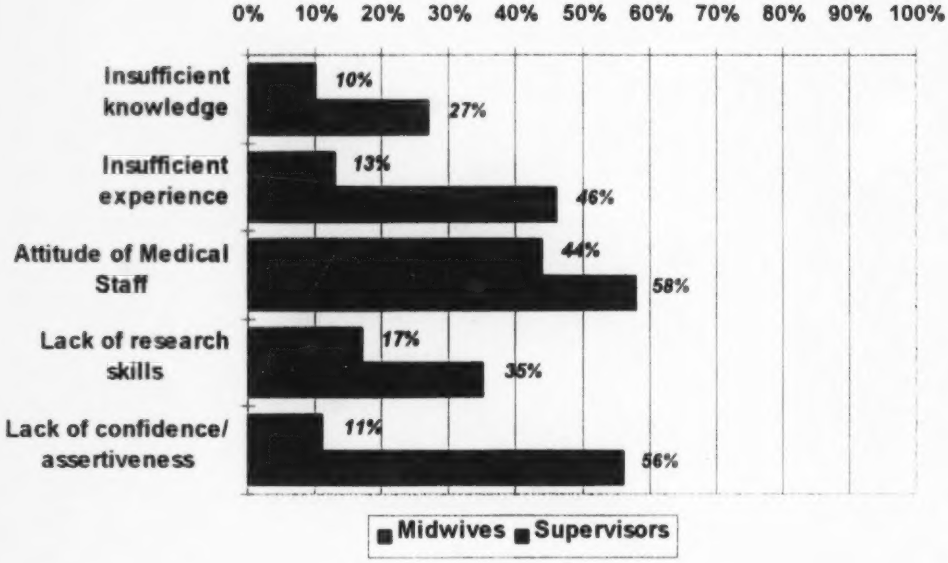
Midwives and supervisors perceptions of factors that prevent midwives undertaking their full role varied considerably. Some of the interesting differences have been presented in the Figures 5.23 and 5.24 below.

Figure 5.23: Barriers to midwives undertaking their full role (structural and organisational)



There were several significant differences between the two groups($p \leq .00001$)

Figure 5.24: Barriers to midwives undertaking their full role (interpersonal and knowledge/experience)



There were several significant differences between the two groups($p \leq .0009$).

On the whole, midwives considered that organisational and structural issues were more likely to prevent them from undertaking their full role. Supervisors were more likely to consider a lack of confidence and knowledge/experience constituted a barrier to midwives practice.

2.2.2 Involvement of midwives in inappropriate roles.

Supervisors were more likely than midwives to consider that midwives undertook inappropriate roles($p < .00001$). Forty four percent of supervisors and twenty one percent of midwives commented. Clerical/administrative work and domestic duties, such as cleaning rooms and making beds were identified as areas where midwives were most likely to be involved in inappropriate work. Chaperoning doctors and assisting them in clinics was also frequently identified as an inappropriate role by the midwives and supervisors who commented. Finally, a wide range of other tasks were listed by a minority of midwives as being inappropriate for midwife involvement. These included: *managerial tasks such as arrangement of shifts for sickness cover and ordering replacement stores, giving out questionnaires, liaison with students, weighing placentas, ward rounds with medical staff, scrubbing in theatre for caesarean sections or termination for fetal abnormality, inserting venflons, scanning, HIV testing, teaching junior doctors and caring for private patients.*

2.3 CONTINUING EDUCATION AND TRAINING NEEDS OF MIDWIVES

Eighty three percent of midwives and ninety two percent of supervisors commented on the areas in which midwives required further education or training. The areas identified by the two groups were very similar. The area identified by the most midwives was research, followed by clinical skills, counselling/ communication skills and general issues related to professional practice. Supervisors identified both clinical skills and research as priority areas, followed by counselling/communication skills and general issues related to professional practice.

Some midwives identified need in more than one area.

Although research was identified by most midwives, clinical practice was most frequently identified overall as some midwives indicated need in more than one area of clinical practice. The most frequently identified clinical area for further education or training was IV cannulation, followed by perineal suturing, ultrasonography, labour and delivery in water and interpretation of CTG's. Other areas mentioned less frequently included epidural top-ups, resuscitation of the newborn and adults, forceps and ventouse deliveries, alternative therapies and neonatal issues (e.g. heart and lung checks). Supervisors identified broadly similar needs as midwives in this respect except that resuscitation of adults and the newborn was identified as the main priority area.

Infant feeding issues were fairly commonly identified by both midwives and supervisors.

Research was commonly identified as an outstanding area for further education. The majority of midwives who commented indicated that they would like to know more about which research findings should be used to inform practice, and how research can best be used in conjunction with other information in relation to practice. In particular, the need for a balance between clinical and technological skills and other types of knowledge required to provide optimum quality care was raised as an important issue. Supervisors also placed emphasis on the importance of being able to use research appropriately to inform practice. Particularly if it was likely that the baby would be ill or disabled.

Communication and/or counselling were also frequently identified as areas of outstanding educational need. Over half the comments from midwives related to general issues such as communicating with, or counselling women in relation to the choices they may wish to make for pregnancy and childbirth and/or informing them of the likely outcome of their pregnancy.

Other areas identified less often included counselling for bereavement, HIV/AIDS, preconceptual and genetic counselling, counselling for antenatal screening tests, smoking cessation, stress and postnatal counselling. The need for further education in relation to inter-professional relationships and assertiveness was also specifically identified. The need for further education in relation to communicating with women from a range of social or cultural backgrounds was also identified. Supervisors emphasised the importance of midwives' communication skills particularly in relation to negotiating care with both women and doctors.

'General professional issues' such as further education in the management of change, ethico-legal issues, accountability, autonomy and professionalism was the other main category identified by both midwives and supervisors in relation to outstanding need. Midwives frequently raised concerns regarding possible disciplinary litigation proceedings if the care provided was subsequently questioned by managers, supervisors or service users. The most appropriate way of dealing with such issues while working effectively within organisational structures to negotiate optimum quality care for women was raised as a continuing education need for some midwives.

Supervisors placed particular emphasis on the need for midwives to have further education in relation to a wide range of 'management' issues, including time management, the effective use of resources and the management of change.

There were a number of comments to indicate that some part-time midwives found particular difficulties in relation to finding the time and resources for study. The following quote exemplifies the comments made.

"Working part-time I have found that when doing any courses or attending study days, I am expected to do it all in my own time".

Finally, both midwives and supervisors acknowledged the importance of identifying and addressing individual need when programmes of continuing education are being planned, particularly in relation to the effective integration of theoretical and practice related issues.

SECTION 3 INFORMATION FROM PROFESSIONALS WORKING IN THE SAME UNITS

The way in which the data have been analysed is as follows:

1. The extent to which midwives agreed with each other.
2. The extent to which midwives and supervisors agreed with each other.
3. The extent to which supervisors and consultants agreed with each other.

The data that have been outlined in this section indicate the extent to which professionals agreed with each other on key issues, when information from professionals working in the same unit was supplied. This could mean that they agreed that a practice occurred in the unit, or that the practice did not occur . For example, the information provided below indicates that in 24% of the units midwives agreed with each other that a system of staff rotation was in operation, **or** they agreed with each other that a system of staff rotation was not in operation.

3.1 MIDWIVES AGREEMENT WITHIN UNITS

3.1.1 Provision of services

(i) Staff rotation

In 24% (n=14) of units all the midwives agreed with each other regarding whether or not there was a system of staff rotation in operation.

(ii) Implementation of Changing Childbirth

Table 5.1: The number of units in which all midwives agreed regarding the extent to which Changing Childbirth was being implemented (n=59).

Changing Childbirth Implementation	Number of Units
Are all women entitled to carry their own notes?	30
Do all women have a named midwife?	6
Are all women fully informed concerning their care?	16
Is a midwife the lead professional for low risk women in 30% or more of cases?	7
Do all women know who their lead professional is?	3
Do at least 75% of women know the person who cares for them during their delivery?	7
Do midwives have direct access to some of the beds in all your maternity units?	1
Are at least 30% of women admitted to maternity units under management of a midwife?	3
Do all women have the full range of choice regarding place of birth?	5
Implementation will improve the quality of maternity services?	34

3.2 MIDWIVES AND SUPERVISORS AGREEMENT WITHIN UNITS

Data have only presented for units where **all** midwives were in agreement with their supervisor.

3.2.1 Provision of maternity services.

(i) Staff rotation

In a total of 14 units all the midwives agreed with each other concerning whether or not a system of staff rotation was in operation. In these 14 units, 4 instances occurred where all the midwives agreed with the supervisor concerning whether or not a system of staff rotation was in operation.

(ii) Implementation of Changing Childbirth

Note: Data is only presented for cases when **all** midwives within a unit agreed with each other. Column 1 indicates the number of units where all the midwives in the unit agreed with each other. Column 2 indicates the number of units where all the midwives agreed with the supervisor.

Table 5.2: The number of units in which midwives and the supervisors agreed regarding the extent to which Changing Childbirth was being implemented

Changing Childbirth Implementation	Number of Units	
	Midwife 1	*Supervisor 2*
Are all women entitled to carry their own notes?	30	25
Do all women have a named midwife?	6	5
Are all women fully informed concerning their care?	16	12
Is a midwife the lead professional for low risk women in 30% or more of cases?	7	2
Do all women know who their lead professional is?	3	1
Do at least 75% of women know the person who cares for them during their delivery?	7	0
Do midwives have direct access to some of the beds in all your maternity units?	1	1
Are at least 30% of women admitted to maternity units under management of a midwife?	3	1
Do all women have the full range of choice regarding place of birth?	5	5
Implementation will improve the quality of maternity services?	34	22

3.3 SUPERVISOR AND CONSULTANT AGREEMENT WITHIN UNITS

3.3.1 Provision of services

(i) Lead professional

Table 5.3: The number of units in which the supervisor and consultant agreed regarding which professional group should be the lead professional for low risk women (n=34)

Lead Professional	Number of Units
Antenatally	22
During labour and delivery	23
Postnatally	26

(ii) Implementation of Changing Childbirth

Table 5.4: The number of units in which the supervisor and consultant agreed regarding the extent to which Changing Childbirth was being implemented (n=34)

Changing Childbirth Implementation	Number of Units
Are all women entitled to carry their own notes?	28
Do all women have a named midwife?	19
Are all women fully informed concerning their care?	22
Is a midwife the lead professional for low risk women in 30% or more of cases?	25
Do all women know who their lead professional is?	19
Do at least 75% of women know the person who cares for them during their delivery?	21
Do midwives have direct access to some of the beds in all your maternity units?	17
Are at least 30% of women admitted to maternity units under management of a midwife?	18
Do all women have the full range of choice regarding place of birth?	15
Implementation will improve the quality of maternity services?	16

CHAPTER 6: CASE STUDIES AND INTERVIEWS WITH NATIONAL ORGANISATIONS

The results from the case studies have been presented in this chapter, followed by an overview of the key issues that emerged from the interviews that were undertaken with representatives of national organisations.

The main purpose of the case studies was to supplement the main body of data obtained for this project, through the questionnaire phase of the study. The findings have already been used for the primary purpose of informing the development of the educational package. The findings from each site have been drawn together to provide an overall picture of the issues that emerged. Where differences were apparent between the sites these have been reported. The data have been analysed through content analysis.

SECTION 1 **BACKGROUND TO THE CASE STUDY SITES**

SECTION 2 **KEY FINDINGS FROM THE CASE STUDY SITES**

SECTION 3 **INTERVIEWS WITH NATIONAL ORGANISATIONS INVOLVED IN THE DEVELOPMENT OF THE MATERNITY SERVICE**

SECTION 1 BACKGROUND TO THE CASE STUDY SITES

Case studies were undertaken in north, south and central England. A small unit employed up to 70 midwives, a medium unit between 71 and 150 midwives and a large unit more than 150 midwives.

Case Study 1 (rural area, small unit)

The site chosen for this case study was a very large rural district made up of a relatively prosperous farming community supporting small towns and villages The hospital that provided maternity care was located within a small town One area of the district served by the Trust had been identified as having particular needs, in that the families were poorer and more mobile, and had higher rates of mortality and morbidity.

The infant mortality rate was below the national average. The annual report for the Trust(1994/5) indicated that the staff were looking at how to change and develop services in order to achieve the recommendations in Changing Childbirth.

There was one NHS GP/consultant unit. The systems of maternity care available included: domino, home births, and shared care. Midwife only beds were planned for the future. Senior midwives and the community midwives did not work within a rotation system, but all other hospital midwives rotated between the maternity wards, clinics and delivery suite, apart from a few midwives on old contracts who worked in one place, on night duty.

Twenty five midwives were interviewed, mostly in groups of between 4 and 8. One midwife was interviewed individually as she could not attend any of the groups. Community and hospital based midwives attended different groups to fit in with their work schedules. Midwives from all grades and parts of the service attended groups. Both night and day staff were interviewed.

The Head of Midwifery/co-ordinating supervisor, two midwifery managers (both supervisors), a general manager and Chief Executive were all interviewed separately. Three GP's (from different practices), one consultant obstetrician and one lecturer in midwifery (from local college) were also interviewed individually.

Case Study 2 (urban area, large unit)

The urban site chosen for case study was part of a large city. The proportion of residents from Black and Minority Ethnic Communities (BMECs) was considerably higher than the national average(1991 census). The district that was served by the Trust ranged from very wealthy at one extreme, to deprived at the other.

Both the maternal and infant mortality rates were higher than the national average.

There was a well defined strategic plan with regard to maternity service delivery which included implementing Changing Childbirth.

There was 1 consultant-managed NHS unit. With regard to the systems of care, domino, home births, team midwifery, shared care, midwife only beds and independent midwifery were available. The system of team midwifery was being piloted at the time the case study was undertaken. One team was in operation with overall responsibility for the care of a group of women in both community and hospital settings. This system was under review.

A rotation system was in operation for midwifery staff but operated in a rather ad hoc manner at the time of interviewing. The team midwives rotated throughout both hospital and community settings, some hospital midwives remained part of the 'core staff' in certain settings and others rotated between clinics and wards.

Thirty eight midwives were interviewed mainly in groups as outlined for case study one. Three individual interviews with midwives were undertaken. Midwives from all grades and parts of the service attended interviews. On the whole, community and hospital based midwives were interviewed separately due to their work schedules, but a small number of mixed groups were convened.

Individual interviews were also undertaken with the Chief Executive, Acting Head of Midwifery, the co-ordinating supervisor, a personnel officer, 3 midwifery managers (all supervisors), one lecturer in midwifery, one consultant obstetrician, one obstetric registrar and 3 GP's from different practices.

Case Study 3 (mixed urban/rural area, medium size unit)

The Trust served a large town well connected by road and rail links, and surrounded on all sides by a large rural area. The population was reasonably homogenous and predominately white, with low unemployment. The rural area surrounding the town consisted of small villages and towns with no major industries apart from arable farming.

Priorities that had been identified by the Trust included: developing the maternity services to incorporate the Changing Childbirth recommendations. The maternity service was working towards a strategic plan/formal policy.

A 'quality' programme was in place that aimed to encourage staff to focus on ways of improving care. Consumer audit was undertaken on an ongoing basis and seen as increasingly important in planning the service in response to Changing Childbirth. Midwifery supervision was also used as a way of highlighting individual staff needs for training and development.

There was one consultant-managed NHS unit. The systems available to provide care included: domino, home births, shared care and GP only care. Team midwifery, caseload management, midwife only beds and the named midwife were planned for introduction in the near future. There was a staff rotation system in operation which was being further developed at the time the case study was being undertaken. Generally, the plan was for E and F grades to rotate within all hospital settings, with a 4-6 month stint in each place. Hospital based G grade staff were mostly likely to spend between 6 months and a year in each setting. Plans for hospital/community rotation were being made, but no further details were available at the time of interviewing.

Twenty seven midwives from all grades and parts of the service were interviewed. The majority of midwives were interviewed in groups. Four midwives were interviewed individually. On the whole, community and hospital based midwives were interviewed separately due to their work schedules, but there were a small number of mixed groups.

Individual interviews were also undertaken with the Head of Midwifery/co-ordinating supervisor, a general manager, 3 midwifery managers (all supervisors), one midwifery lecturer, one consultant obstetrician and one GP.

The number of midwives interviewed in each site varied in relation to the size of the unit, with the most midwives being interviewed in the largest site. The researchers visited each site for several days and were available to undertake interviews at the midwives convenience at any time of the day/night.

In all the case study sites a broad range of midwives (in terms of grade and role) were interviewed but it is important to bear in mind that those who agree to be interviewed in any study, may differ in their views and behaviour from those who do not choose to participate.

All interviews were audio-recorded and notes were also taken. The tapes were fully transcribed for analysis purposes.

2.1 Meeting the Needs of the Local Population

2.1.1 Type of maternity care provided and the implementation of Changing Childbirth

(i) Choice of place of birth

At all of the sites there was lengthy discussion regarding how to ensure that clients could make the choices that they wanted regarding the type of maternity care received. General Practitioners in all sites acknowledged that they had particular concerns in relation to home births which would effectively limit the choice available to women. Two of the GP's interviewed would offer home births if mothers really wanted it, provided there were no contra-indications. The other GP's would not provide home births. Safety was the main reason given for not providing home births, although on questioning, the GP's tended not to provide research-based evidence to support this view. Resourcing issues in terms of the amount of midwife time taken up providing care for those having home births or domino deliveries was also considered to be a barrier to providing such care. Two GP's in the rural case study site raised particular concerns about midwives being 'miles away' delivering a baby, and being unable to get back to run an antenatal clinic.

The consultants were not opposed to home births if the GP's were prepared to provide medical support where necessary, but the consultant from site 2 preferred women to opt for a domino delivery instead, on the grounds of safety. She went on to comment:

"I do slightly worry about the individual that is not given a say in home deliveries and that is the baby".

Midwives from all three sites discussed how the GP's opposition to home births was almost always a barrier to women's choice. In all the interviews undertaken with the midwives, there was only one example given where the GP was seen to really facilitate choice in this respect - and the midwives considered that she took control of the care and prevented midwives from undertaking their full role. Midwives indicated that some GP's refused to provide care for those wanting a home birth, whereas others made it clear they did not favour this option, thereby exerting a pressure on women not to pursue the matter for fear of "offending" their doctor by effectively going against his/her advice.

The midwife in many instances would not see the woman until after the initial discussion with the GP and there was concern that there might be bias in the information provided by the GP, thus affecting the choices women would make.

One midwife indicated strong tactics would come into play if a woman persisted with the wish to have a home birth:

"Once they have written a letter to the woman saying I am taking no responsibility for this and you might die at home, if the woman still says OK, then they say all right, we will accept that and not take you off our list".

The reluctance of GP's in site 2 to refer women to the hospital under the care of a midwife was also seen as an inhibiting factor in terms of promoting choice.

The public's lack of knowledge regarding the role of the midwife was highlighted by both midwives and their managers as a barrier to choice. Women generally went to the GP initially and expected doctors to be involved throughout the pregnancy. On the whole, GP's were seen to collude against midwives undertaking their full role, often for monetary reasons. Some hospital based midwives indicated a lack of confidence regarding home births and identified the need for further experience in this area if they were to be expected to undertake a wider role in the future.

(ii) Lead professional role

There was general agreement between all midwives and the consultants at the three sites that midwives should assume the title of lead professional for low risk women. The consultants thought it logical that the midwife should be the point of contact for the woman, but that this should not undermine team working. The term 'lead' professional having rather hierarchical overtones in the eyes of some.

General Practitioners did not really support the idea of the midwife being the lead professional, favouring either a joint role in this respect, or considering that the GP ought to take the lead role in care. However, one GP did say:

"I don't know whether I could put my hand on my heart and say we actually do anything very useful, if I am quite honest about it."

Another had a very high regard for midwives but remained involved in the care

"The midwives here are the experts, we just come along and join in a bit".

However, the actual role midwives fulfilled in the eyes of one GP was rather open to question:

"Midwives do not need to visit so much postnatally as it is actually an intrusion. They could visit once maybe to make sure that there is no King Kong wandering drunk in the house, but after that it could be done on request".

Midwives were generally happy to work alongside GP's but did not agree that the GP should be the lead professional. This was largely due to the fact that GP's were mostly not involved in providing intrapartum care. Midwives accepted that women may choose to be seen only by a GP antenatally, although this was seen to affect continuity in the post-natal period. However, GP's were less happy if the client opted to have midwifery only care. It was generally seen as an unnecessary break in their relationship with their patients, particularly as it was considered that most women needed medical input at some stage of pregnancy.

Midwives in sites 1 and 3, accepted that the GP would know the family and want to be involved, whereas in site 2 the obstetric skills of GP's was questioned more, as was their capacity to really know all their patients to the point of being able to provide a continuity of care that would be beneficial to most women. One midwife commented that healthy women often do not have regular contact with their GP.

The argument that GP's would lose contact with families was not accepted by managers and some of the midwives. General Practitioners were generally seen to be happy to refer to other specialists, and referring to the midwife was not considered to be any different. One midwife indicated:

"The way I see it if she has a heart problem he would send her to a physician, if she has appendicitis he would send her to a surgeon. The midwife is the expert as far as normal pregnancy and childbirth go".

The issue of payment was considered by some midwives to be the reason for GP's reluctance to allow midwives a more pivotal role in care.

(iii) Implementation of Changing Childbirth

There was generally a poor knowledge of the origins of the Changing Childbirth report and this confusion was shared by both doctors and midwives. This related particularly to the indicators of success. The midwives from all three sites knew that the report had involved Baroness Cumberledge but were generally unsure of the role of the professional bodies or how representative the public opinion was that was used to underpin the report. However, the community midwives in one site had a thorough knowledge of the link between the Winterton Report and Changing Childbirth and viewed both reports very positively. However, at the other extreme one group of midwives was of the opinion that:

"The Committee sat and decided to inflict it on us".

The report was seen to be generally helpful by midwives in terms of re-empowering the profession, with some considering it a 'midwife's charter', but there were concerns from all groups in terms of how it would work in practice, particularly in relation to the effects on midwives hours of work and conditions of service. One supervisor summed up the situation thus:

"They are supportive of the principle and are keen to take the challenge on, but they are devastated about what it might do to their lifestyle, and they are very anxious about changes to rostering, terms and conditions, where midwifery is going, what grade they are going to be on, is there going to be a grading structure, is it going to be local pay determination - they are anxious about it really, and suspicious".

There was wide discussion in all three sites concerning whether the percentages cited in relation to the indicators of success were realistic, and research-based. The ambiguity with which some of the indicators could be interpreted was considered a problem. This being particularly relevant in relation to:

"at least 75% of women knowing the person who cares for them during their delivery".

It was often considered that the concept of 'knowing' the midwife could be widely interpreted, and was likely to vary in its importance from client to client. Midwives generally considered the priority was to ensure that women were cared for by someone they considered '*caring, kind and competent*' .

The safety aspect of delivery was considered paramount by both doctors and midwives. It was widely considered that provided the midwife was skilled and had a caring approach then it was possible to build up a rapport in a relatively short space of time, with one midwife describing it as *'the quickest made friendship'*.

General Practitioners considered it impractical for midwives attached to GP practices to deliver women and run antenatal clinics and provide postnatal care. The proposals to introduce team midwifery and for midwives to rotate between the community and hospital settings was not generally favoured by GP's who preferred to have the same midwives (usually a small number), attached to the practice - which they thought would be jeopardised by the introduction of new ways of organising care.

On the whole, midwives and their managers thought that once it was organised properly, women would be introduced to the team and delivered by one of the midwives within that team. The size of the team was considered fundamental to how well it would work, and for the avoidance of stress on individual midwives. With regard to the 'named midwife', similar discussions tended to ensue as for the indicator related to 'women knowing the person who care for them during delivery'. It was not always considered possible for women to consistently see one 'named midwife'.

Midwives generally seemed to be very committed to their job, and found a great deal of satisfaction in midwifery, but were anxious in terms of meeting 'on call' rotas and managing commitments outside of work. There was particular caution from midwives in sites 2 and 3, where team midwifery had been introduced and failed:

"We had a small team here and we were on our knees within a year".

Another midwife commented:

"I ended up delivering 2 women, and I did not belong to that team and that caused hassle actually, because the person was so hyped up to expecting to be delivered by one of the team and she wrote a letter of complaint".

Midwives who had positive experiences in other units were generally much more optimistic about the benefits of team working:

"I've worked in team and primary nursing on the general side, and the morale you got from working in a team and working and pulling together was brilliant".

Long discussions took place, particularly amongst the midwives about the best way of organising team midwifery, without any clear conclusions emerging. It was generally considered that teams should have about 5 or 6 midwives in them, if mothers were to stand a reasonable chance of meeting them all throughout their care. However, this was not considered feasible in 2 of the sites in the light of the large number of women needing care from a relatively small number of midwives. Each team would have to look after far too many women to provide optimum care. In one site, when the team approach had been introduced sometime earlier, there were up to 40 midwives in a team - which did nothing to facilitate women being cared for by a midwife she had previously met.

There was general agreement that midwives needed support in terms of implementing the changes proposed by Changing Childbirth. Such support was not considered forthcoming in many cases as managers and supervisors were seen to be committed to pushing through changes whatever the effect on the midwives, which made many of them feel the 'passive recipient' on the end of an unmanageable process. Managers on the other hand, were more likely to express exasperation at some midwives apparent refusal to take an active part in the change process.

The financial and educational implications of Changing Childbirth were seen to be immense, particularly for midwives. The added problems of low morale generally within the midwifery profession and the opposition of GP's to midwives undertaking their full role were seen to present insuperable barriers to implementation by some midwives, particularly those who had been working in the community for many years.

Very few discussions included any spontaneous reference to any other ways of ensuring continuity of care. However, one of the consultants made an interesting observation in relation to continuity of carer:

"Advice from the midwife, advice from the auxiliary, advice from the man upstairs and then they go home hopefully to a single midwife with singular advice".

2.1.2 Social and cultural needs

Sites 1 and 3 did not have the same diversity of population as site 2, and social and cultural issues were discussed much less in these two sites by both doctors and midwives. The attitude of midwives from sites 1 and 3 towards Black and Minority Ethnic Communities (BMEC's), seemed to be one of 'assimilation'. Managers and midwifery lecturers from these sites also discussed how midwives expected women to conform to the way of life of the indigenous population. A small group of Filipino women had recently come to live in one of the study sites, and were described by midwives as *"doing their best to fit in"*. Midwives generally indicated the importance of understanding the needs of women from a diversity of social class backgrounds. However, some indication of rather stereotyped views was apparent.

Midwives and managers in site 2 discussed the difficulties in providing care for the many diverse groups in the area. Ethnicity, poverty and disability were the main issues discussed. On the whole, a lack of resources and the attitudes of some midwives were seen to be the main barriers to meeting the needs of all groups. With regard to meeting the needs of BMECs, a dramatic increase in the number of link workers was considered necessary, including link workers for the more unusual languages. Some midwives clearly wanted to be able to meet the needs of all women using the service. The following comment was made a midwife when discussing how to facilitate women wanting to breastfeed their babies:

"Women want to do it and one of biggest reasons why they can't is bad intervention by midwives and lack of understanding by English professionals"

Another midwife's comment indicates her awareness of some of the problems that occur in this area:

"Racism is rarely mentioned, but I feel that midwives are sometimes insensitive and irritated by necessary differences in caring for women from different religious, cultural and ethnic backgrounds - it is often regarded with flippancy".

2.1.3 Quality of care

Various aspects related to quality of care were discussed throughout the interviews as can be seen from much of the information presented in this chapter. However, during interviews questions were also specifically asked relating to what professionals considered quality care to be, how it could be assessed and monitored, and what makes a 'good' midwife.

A broad range of issues were discussed regarding quality care. Medical staff were more likely than midwives to initially focus on clinical care and outcomes. One consultant described quality as:

"quality received by the patient, quality which can be measured such as pain relief, procedures and perinatal outcome".

His second point related to the importance of the doctor and midwife considering from a professional point of view that the pregnancy had been a satisfactory one. Another consultant mentioned the importance of both a successful outcome and tailoring the care to the individual's needs with minimal intervention. The issue of mother's satisfaction was touched on by a registrar who considered that professional peer review was more valid than the consumer satisfaction surveys that were undertaken in his unit:

"*I am afraid that there is always going to be a proportion of patients who are not going to be satisfied with their care even though by any objective outside standards what they have is good quality care".*

The GP's discussed the importance of making a 'good medical diagnosis' and detecting problems as early as possible. However, one GP also commented that having a happy pregnancy with people interested in her (the mother), and taking home a healthy baby at the end of it was the most important aspect of quality care. A registrar discussing a similar point indicated that having a healthy baby and high quality care were not necessarily synonymous. He considered that some of the best quality care was motivated by tragic situations such as stillbirths.

Midwives tended to focus initially on having a 'satisfied mum' and went on to discuss the ways in which they would know whether that had occurred. Satisfaction surveys were widely used, but midwives considered that they would know if the mother was satisfied by the way she interacted with the midwife. The following extract from a conversation between 3 community midwives in a research group typifies this:

midwife 1 *"when your woman has had her baby and you're leaving on the 10th or 28th day and she says she's had a nice delivery and she's been happy with her care";*

midwife 2 *"And she classes you as her friend rather than her midwife";*

midwife 3 *"And she'll say to you pop back and see me whenever you want, not just get out of the house I don't ever want to see you again".*

The importance of considering individual need was exemplified in the following way by one midwife in a senior management position:

"My personal example is a woman who had an epidural, who was from a background where the whole thing terrified her. She wanted it all to be very medical, because that made her feel safe. She wanted the CTG beside her, she wanted the sound up. That was not the way I would deliver care, but by delivering it in the way she wanted, she felt at the end of it that she had a great experience. If I looked at that on paper I would think 'oh, that poor woman' - but good care is about adjusting what I am doing to meet her needs."

However, not all opinion was in the same direction and one midwife considered providing high quality care meant:

"knowing we are right when the patients tell us that we are wrong".

(i) Quality monitoring

With regard to quality assessment and monitoring, GP's were least likely to indicate that any formal method of quality monitoring was taking place. One GP did not consider formal monitoring necessary *as:*

"if women were not happy we would have heard about it by now".

Morbidity and mortality data were available and were used by GP's to assess the outcome of maternity episodes. Hospital staff discussed clinical audits and patient satisfaction surveys in relation to quality monitoring but there did not seem to be a clear focus for quality monitoring that everyone was involved in, or indeed aware of. Managers tended to discuss monitoring the implementation of government initiatives such as the Patients Charter and Changing Childbirth, with a vague emphasis on providing 'cost-effective care' without any clear indication of how this might be achieved. Doctors tended to mention clinical audit, and midwives were the least likely to spontaneously discuss formal mechanisms regarding quality monitoring.

Consumer satisfaction surveys seemed to focus on rather 'general satisfaction' issues (which have not been found in the literature to discriminate very well). One site produced consumer satisfaction surveys in languages other than English. However, there was little indication of developed strategies aimed at finding out more about issues of access and acceptability of services to women from specific population groups.

There was very little mention of the types of information that might usefully be drawn on to inform the provision of quality care (e.g. clinical knowledge, research-based knowledge etc.).

(ii) 'Good' midwifery care

Following the above discussions, professionals reflected on what makes a 'good' midwife. The consultants tended to discuss clinical competence as being most important, followed by inter-personal aspects, whilst the GP's considered inter-personal skills and caring as priorities, followed by clinical and technical aspects of care. This may have reflected their view that generally midwives were more competent in clinical areas than in the inter-personal domain.

Midwives discussed the issues with each other, generally concluding that being a good communicator and listener, empathetic, flexible and approachable were most important. Being knowledgeable and clinically competent were also mentioned in most groups. The issue of how one becomes knowledgeable was also discussed. (Further details are outlined below under the education and training need section).

The need for care to be suitable for each individual was discussed with the following quote from a midwife indicating the importance of this:

"Accepting people, if they say they are in pain then, yes, they are in pain, and believing them and trusting them to know how they are feeling".

Another frequent topic of conversation related to the wide variation in midwives' views and behaviour, with all the groups agreeing that such variation existed in the area in which they worked, which clearly affected the quality of care provided to the local population.

2.2 Autonomy and Accountability

The issue of how to define autonomy and whether the midwife could be truly autonomous was debated at length at all three sites. Generally, midwives described autonomy as "being responsible for your own actions", with one midwife commenting:

"It means taking the blame when you get it wrong".

In all three sites midwives identified doctors and unit protocols as key barriers to autonomy. On further exploration some confusion emerged in relation to whether midwives considered you had to be working alone and making all decisions to be autonomous. Some considered this to be the case, whereas others took the view that it was being able to make your own decisions and stand by them, even when that decision was to seek advice or help. Interesting discussions ensued about the provision of 'total' care by midwives with the general view tending towards this meaning providing all the *midwifery* care required, but others may still be involved in providing other aspects of maternity care.

The community midwives tended to discuss the referral practices of doctors and the effect it had upon midwives practice. In site 3, GP's refused to refer to the midwife who had responsibility for ultrasound scanning in the community. In site

1, all women requesting home births were referred to the consultant at 36 weeks in order to satisfy GP's that the birth was likely to be normal. This was despite the fact that the GP would not be attending the birth. Community midwives at site 2 had problems in persuading GP's that referrals could be made directly to midwifery led beds at the hospital.

Hospital midwives discussed being restricted by hospital protocols which were thought to have been mostly devised by consultants. Fear of litigation was another barrier identified by all midwives which posed problems in terms of promoting client choice and having to adhere to policies or procedures. Lack of knowledge and insufficient time to undertake study was seen as a barrier to autonomy by some midwives, who recognised the need for more education. It was however, also accepted that even if further education were provided that there would always be a small minority of midwives who preferred to take orders from others rather than accept responsibility.

Managers from sites 2 and 3 discussed problems they were encountering with local GP's. This was related to the planned introduction of midwifery led care in site 2. In site 3 the problem arose because 50% of the local GP's were fundholders, and managers perceived that they wanted undue control over midwives' practice for monetary reasons. The importance of midwives being adequately represented within the Trust/Authority decision making structures was frequently stressed by midwife managers.

The consultants from sites 2 and 3 favoured working as a team and did not think that the midwife should be completely autonomous. When asked to define autonomy they talked about *"making decisions and taking responsibility for your actions"* - which they seemed to consider would conflict with the team approach in relation to the provision of midwifery care. On further exploration it transpired that they felt that doctors could work in a team but still be autonomous - as they would technically 'lead' the team.

Both consultants considered that the doctor should be able to enter the delivery room and that this should not be seen as interfering with midwives' autonomy. There was concern that midwives would only expect them to rush in if there was a serious problem, whereas it could be more reassuring to the woman experiencing problems in labour, if they had met the doctor before - thereby ensuring continuity of care. However, a registrar put forward the following view:

"You could argue that registrars or consultants wanting to know what was going on in the delivery suite means that they still have overall responsibility with the midwifery leader. and it could interfere with midwives autonomy".

The consultant from site 1 did not view midwives as being autonomous in any respect and this was largely due to the fact that they were seen to either lack knowledge or refuse to take responsibility. He also considered that midwives could recognise when a woman was moving from low risk to high risk but they did not always know the significance of it. This did not seem to be the opinion of the consultants from the other two sites but they were both specifically worried about the midwives ability to recognise maternal heart problems, and whether they had sufficient knowledge to manage high risk deliveries.

The GP's discussed how community care would remain the same for both low and high risk women, but hospital care would change, with midwives taking less responsibility in high risk cases. The GP's considered that midwives could be autonomous up to a point, but that autonomy meant the midwife should be called out when women were experiencing problems such as threatened miscarriages rather than the GP. This point raises interesting issues in relation to the role of the midwife in low/high risk care which has been followed up in the discussion in Chapter 8.

2.2.1 Accountability

With regard to accountability, the main concerns raised by midwives related to potential disciplinary and/or legal action being taken against them. Midwives generally saw documentation as being vitally important in terms of avoiding litigation. They discussed the difficulty of documenting effectively whilst dealing with emergency situations. Most midwives considered that for their own protection they should inform either the supervisor or manager if the woman rejected their advice.

Midwives displayed a mixture of views regarding litigation. Some felt that provided documentation was effective and Trust policy had been adhered to, that the midwife would not be sued or disciplined. Other midwives, had been made fearful by recent cases reported in the media where disciplinary proceedings had been taken against midwives who had been involved in water births.

The consultants generally considered that midwives would have to defend their own actions but would be insured under the Trust policy provided that they had documented thoroughly. The issue of midwives refusing to make decisions in case they were held accountable was also raised. One consultant commented:

"Apart from the clinical knowledge, some of it is about taking responsibility for what you are doing and updating yourself and learning, having the skills and confidence to make you do that rather than keep asking someone every week what you have already asked them the week before".

The issue of legal responsibility generated considerable confusion in relation to midwives working with GP's. There was no consensus of opinion as to who would ultimately be responsible. Some GP's believed they would remain responsible even if the woman was only seen by the midwife whilst others believed that the midwife would be responsible for any actions she had taken.

The issue was further complicated in the case of home births, particularly as the GP would not be obliged to attend in the same way as the midwife would, but some GP's still thought they would "carry the can" if the midwife was accused of making a mistake:

"You can't have autonomy and dump the bits you don't like on the doctor".

2.2.2 Supervision

There was much debate, particularly amongst the midwives about the role of the supervisor in facilitating or restricting practice. There was a general feeling that there was a conflict between the 'management' and 'support/friend' role.

In all the study sites, all the supervisors were also managers, although they did not always manage and supervise the same midwives. The managers/supervisors were more positive than midwives about the benefits of splitting their duties so that they did not manage those they supervised. Midwives expressed doubts about the capacity of some managers to make effective supervisors - full stop. Supervisors were seen to need an excellent knowledge of all aspects of midwifery practice, with some managers being considered rather out of touch with current developments due to lack of regular clinical practice, particularly in relation to intrapartum care, where most problems were expected to arise for midwives. Some midwives considered that a midwife who had provided care for several years and continued to be heavily involved in this type of work, without carrying extra management responsibilities would be the best supervisor.

In one site, the midwives all agreed that they should elect their supervisors but the issue was viewed with a certain amount of caution in the other sites, where it was felt that this may lead to some midwives choosing those they considered would give them an 'easy ride', which may not be in the best interests of those using the service.

The general feeling seemed to be that the supervisory role was more punitive than supportive. In all the study sites at least one midwife had faced disciplinary action in the recent past. This was alluded to in each site during interviewing but it caused obvious discomfort in all groups where midwives chose to discuss it. The midwives clearly held diverse views on whether the disciplinary action had been justified, and did not appear comfortable to enter into the debate with colleagues in the research group. Supervisors had been involved in some way with the midwives who had been subjected to disciplinary proceedings, leading to a certain wariness on the part of many midwives to confide difficulties to supervisors.

In one site, the supervisors met with each midwife at least annually to discuss any problems or areas of outstanding need, and agree a developmental plan for the year ahead. Plans were being made in the other 2 sites to make the supervisor/midwife relationship more structured and positive, as there was a feeling amongst the midwives that they only saw the supervisor in times of potential trouble.

One manager/supervisor indicated that she felt quite concerned about the way her role was perceived by the midwives:

"Although I feel I have a close relationship with community midwives, I am always astounded that when I walk in and say can I have a quick word, that people say 'what have I done?' I think, 'heavens, am I really that much of an old bag?'".

None of the midwives or managers indicated that they considered there should not be such a thing as a supervisor role, with the potential benefits to both midwives and mothers being acknowledged, if the system operated effectively.

The doctors spontaneously mentioned the 'harshness' of the midwifery disciplinary structure (which supervisors were seen to be associated with), in relation to the corresponding medical system.

2.3 Confidence/Competence of Midwives to Practise

Leading on from the above discussions on autonomy and accountability, the level of confidence and responsibility assumed by the midwife was highlighted by health professionals in all three sites. The midwives in sites 2 and 3 appeared to be much more confident than the midwives in the site 1. This seemed to be related to the midwives in site 1 having had less exposure to a range of practice situations. Midwives from all three sites expressed doubts in relation to performing at the same level of competence when they were rotating to different environments. Some element of rotation was evident in all three sites, although the midwives did not necessarily consider the system operated systematically or in their best interests. Not all staff worked within a system of rotation, which led to feelings of unfairness arising. Some staff had contracts for permanent night duty, whereas others had to work within an internal rota system. In 2 of the sites this caused particular concern amongst those who had to rotate between day and night duty.

Working within a system of rotation generally affected confidence because it was associated with 'not knowing the pattern of working and the environment'. Particular concerns were raised in relation to working on the delivery suite. Midwives, particularly those based within the community often did not consider they got sufficient experience of carrying out "high-tech" hospital deliveries to render them competent in this area. In one site the community midwives all did a 2 week annual stint on the delivery suite, which both they and their hospital colleagues dreaded as neither considered the community staff capable of providing adequate care. Generally, the managers and supervisors supported the rotation concept, although it was not considered to be appropriate for all midwives. As one manager put it:

"I can think of 2 midwives off the top of my head who are never going to be any good in delivery suite, would be miserable in there, but give wonderful care in the postnatal ward. We have a place for them because it is really nice to have someone who loves cuddling babies and making horlicks".

Another factor affecting the confidence of midwives generally was the public perception of the role of the midwife. Midwives felt that they had to work hard to convince the public that they did not necessarily have to see a doctor during the pregnancy in order to receive high quality care. The medicalisation of childbirth was cited by midwives as a key reason for this. Community midwives considered the GP's a particular problem in this respect, often making a point of seeing all mothers.

There was general agreement from midwives in all three sites that the midwife needed to be re-empowered. The most important factors identified in this process were considered to be a change in doctor's attitudes and the support of management for midwives to have more scope to make decisions without being constantly restricted by local policies and procedures - which were often set by doctors. Midwives often did not consider they could really influence either of these issues. However, it is interesting to note that some community midwives in all sites indicated how they often supported mothers in their wishes for a home birth, and helped them find another GP if necessary. Another example, frequently given by hospital midwives in relation to having the confidence to practise without the assistance of a doctor related to vaginal examinations in labour. One midwife summed up the situation by saying:

"I tell him I have just done it, and he goes away".

Hospital midwives from sites 2 and 3 were generally very confident in terms of inter-professional relationships. They considered that the doctors working in the unit listened to and respected their views. The confidence of the midwife seemed to have a bearing upon how much responsibility he or she assumed. The lecturer and the managers from site 1 perceived that midwives wanted to take more responsibility but needed more training because they were used to deferring to doctors and were unsure of their position legally.

Managers in site 3 discussed how advocacy was related to the assertiveness of the midwife and her ability to represent the client's view. It was perceived that the newly qualified midwives were more confident than the midwives who had been qualified for years. The consultant in site 2 echoed this view and thought it puzzling given the difference in work experience. Midwives themselves identified feeling undermined by the qualifications and knowledge of newly qualified midwives.

The consultant from site 1 considered that midwives were either lacking in knowledge, or did not want to take responsibility and this was the reason why they referred to doctors who were often senior house officers with far less experience than themselves:

"SHO is more confident after 2 weeks than a midwife is after 10 years".

The system of working was seen as the reason for midwives lack of confidence by the consultant in site 1, and by three of the GP's - midwives had simply become accustomed to having a doctor there. General practitioners in particular thought that midwives did not appear to have the confidence commensurate with their knowledge and expertise, nor would they often accept responsibility, as outlined earlier. Doctors also agreed that the public would need to be educated in order for them to appreciate the skills of the midwife.

2.4 Continuing Education and Training Need, and Development of the Educational Package

In terms of the continuing education and training needs of midwives, key areas were identified by many of those interviewed. A summary of these issues has been outlined below, with the key emphasis on the issues that needed to be addressed through the educational package that has been developed.

The importance of providing the best care possible was considered to be the main priority for midwives. Many topics were discussed in this context, particularly in relation to the issues discussed above.

2.4.1 Research related issues

(i) Midwives', managers' and educators' views

Greater research awareness was seen by many of the midwives as important in relation to informing care. This was spontaneously identified in all the interviews with midwives, but on further exploration a diversity of views and understanding existed. Initial discussions tended to focus around the fact that midwives were often 'made to feel guilty' for not using research more to inform their practice because managers, educators, and frequently mothers expected them to do so. This did not mean that midwives were against using research to inform practice, but often they just did not feel as though they had the necessary skills to decide which research studies should be used, and in which circumstances. Some midwives felt rather intimidated by the current 'research culture', seeing it as something they may not have the intellectual capacity for.

Discussions often moved on to how research can best be used in conjunction with other sorts of knowledge and expertise - such as that gained from years of midwifery practice. There was a feeling that often only research-based knowledge was considered important by managers and the medical profession, sometimes leaving midwives with the impression that their contribution to the service was not really valued. One midwife commented:

"The thing that stands out in practice when you work with other people is just common sense and compassion, and there is no way you can educate for that".

When midwives were asked whether they used research to inform their practice, many of them indicated they had made one or two attempts to base their practice on a piece of research they had read, often without success, as the doctors dismissed the study as not being very good and the managers did not support the midwives case. Those who had recently studied to diploma or degree level had often had difficult experiences in relation to research, particularly if they had to collect data on a practice related topic for a research dissertation or project. They did not feel they had learnt a great deal from this, but completing the exercise had caused them a great deal of anxiety.

Not many midwives were very familiar with the information related to research available for those working in the maternity service. There was very little awareness of a national research and development strategy for the NHS. Fear of not being able to understand material, and not having time to read complicated research studies, which looked 'boring' seemed to constitute key barriers to more effective use of research.

The problem of changing traditional ways of practising was highlighted in site 2. The community staff followed research on cleaning umbilical cords whereas the hospital midwives, despite their knowledge of the research, continued to use the traditional method - because *'we think it works'*. During a discussion on the use of research in practice, one midwife indicated:

"we'll carry on the same way here thank you very much".

Midwives in site 3 showed the most enthusiasm for learning more about research. There was a research midwife in post who was seen to be a good source of advice and encouragement.

The issue of lack of time to perform research was mentioned by many midwives, as were poor facilities, in terms of access to libraries and journals. The idea that midwives should all be doing a 'bit of research' seemed to be rather pervasive. One midwife commented:

"I have got a little research project that I am doing on the side, when I am not sleeping".

It was not very clear why midwives felt they should all be doing research, as on further discussion this was not seen as the best (or safest) way of gaining the necessary knowledge and skills to inform practice. It was rather vaguely indicated that *'they expect it of us'* (the managers). However, none of the managers interviewed thought all midwives should be doing research.

One group of midwives were very vociferous about the way midwives are disadvantaged in relation to the medical profession, which was exemplified by the following quote:

"Perhaps we need to look at how the medical team use their research. They have research posts that we are not given".

Midwifery lecturers discussed how traditionally trained midwives were frightened by the word research and felt inferior to the newly qualified midwives who had received teaching on appraising research studies. However, it was perceived that midwives were generally keen to increase their knowledge of research, but often did not know how to achieve this. Interestingly, a student midwife (a 'non-nurse') who came for an interview discussed research and commented:

"I am not sure of the relevance especially when you are training".

Managers generally understood the need for midwives to be able to critique research and supported the need for a regularly updated national database for research. There was greater awareness of research information, with the Cochrane Database, companion volumes and summary being considered important sources. However, midwives were not generally thought to use any of these sources to inform their practice (there was little spontaneous mention of any of these sources in midwife interviews). One manager commented:

"They have been saying at interviews they are research based practitioners but if I ask them for more depth to that answer they cannot say much more".

In fact, a similar situation arose in many of the group interviews with the midwives. When directly asked whether midwifery was a research based profession, the answer was invariably 'yes' followed by a discussion indicating that they did not necessarily have much evidence to support this, but felt obliged to say 'yes' as 'everyone says it should be'.

(ii) Doctors' views

The doctors interviewed did not give a consistent opinion on this topic. Two out of the three hospital consultants commented on this issue and seemed to be generally dismissive. The consultant in site 1 described midwives conducting 'little' projects and the consultant in site 2 indicated that midwives only considered research when it formed part of an educational course:

"They usually come along with a piece of research when they are writing one of their course things".

There was no consensus of opinion from the GP's. One GP considered that research needed to be team focused and multi-disciplinary, whilst another felt that if midwives wanted to be autonomous then they should be performing their own research and not rely upon others. The difficulties in changing practice were acknowledged by one GP thus:

"Antenatal weighing does not make any difference but everybody is still doing it because it is very difficult to get out of the habit".

The need for research to be addressed in the educational package was clearly identified. Midwives and managers/supervisors indicating the need to address the issues outlined above, helping to encourage greater use of materials already available and not to repeat what has already been done.

2.4.2 Clinical issues

The need for updating and learning new clinical skills was never far from many midwives' minds. Working within a system of rotation had brought matters to a head in many cases because new skills were often needed. The most common concerns related to CTG monitoring, perineal suturing and IV cannulation. Community midwives perceived that hospital midwives would be better at skills such as CTG monitoring and perineal suturing, although in fact hospital midwives cited exactly the same issues as being of concern to them - although not always for the same reason. For example, hospital midwives doubted the accuracy of their readings, whereas community midwives lacked experience in actually performing the monitoring because of its general unavailability in the community setting. The main worry focused around getting enough regular experience after completing a 'training' course to maintain competence.

The doctors from all three sites generally agreed that the midwife needed to possess excellent clinical skills, but they did not focus on the issue as much as the midwives, tending to broaden the discussion more quickly. The consultants in sites 1 and 2 made particular mention of midwives skills in relation to CTG tracing. This was in relation to the referral rate to doctors, either as a result of the high rate of false positives, or because midwives did not want to take the responsibility for interpreting the reading. One doctor considered that most medical staff were unable to read a CTG properly, consequently he considered this would be even more so for midwives.

The consultant and registrar from site 2 seemed to be the most satisfied with the clinical skills of the midwives and stated that at least 80% of the midwives working there were clinically competent. The six GP's interviewed did not comment much on the clinical skills of the midwife - they were generally preoccupied with their own clinical skills in terms of maintaining competency - and wanted to discuss this at length - even though this was not the focus of the interviews!

Managers in site 2 discussed midwives' concerns regarding the extension of their clinical duties. It was perceived that midwives felt that they might have less time for clients if they were performing duties previously carried out by the doctor. Concern was also frequently expressed by midwives regarding the clinical skills of 'direct entry' midwives and how to ensure that they were able to recognise underlying medical conditions and perform basic nursing care[1]. Some midwives considered that there may eventually be two types of midwives - those who care for women experiencing normal pregnancy and childbirth, and those with nursing skills who care primarily for those with obstetric or medical conditions. Managers in sites 1 and 3 did not cite any particular areas of concern and discussed clinical skills in a very general way by stating that they were *'important for everyone'*.

The debate on midwives increasing their clinical skills led to some of them feeling that they would be expected to play an increasingly complex role in delivering maternity care, which may move them away from their key role as 'experts in normal pregnancy and childbirth'. One midwife commented:

"From talking to the new midwives, some of them are going through a phase that they don't quite know what is normal".

Another indicated:

"I think that with the changing hours for junior doctors that midwives are afraid that they are going to get thrown all the things that are left over and not done".

With regard to outstanding training need, midwives generally considered that the only way for them to maintain clinical competence was to get regular experience in all the areas they might be required to practice in. There was some concern that managers and supervisors expected midwives to maintain their competence with considerable less regular practice than the midwives themselves considered they required.

Although it was not considered appropriate for clinical skills to be taught through the educational package that was being developed, it was indicated in a number of the interviews with midwives that it would be useful to address issues such as: negotiating training for clinical skills, increasing one's level of confidence to practice - or refusing to be involved in providing a certain aspect of care until

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[1] The term 'direct entry' midwives has been used in this report when those involved in the research used this term, even though this is no longer the approved title for this type of education programme.

competent, and informing clients about the advantages and disadvantages of many popular 'technologies, such as CTG tracing, ultrasound scanning, amniocentesis and alternative delivery positions etc. One midwife commented:

"*We are very dependent on circumstances - it would be nice if you developed something to help us negotiate our practice*".

2.4.3 Communication and counselling skills

There was general agreement from midwives' managers and doctors that good communication skills were vital to the job.

(i) Communication between midwives and mothers

A wide range of issues were addressed in the interviews. Discussions with midwives tended to focus around situations they had recently encountered in their practice leading to many lively interviews. Some midwives talked about generic communication skills that all professionals need to do their job effectively, whilst others focused on more specific issues such as how one communicates with those in difficult situations, such as bereaved parents.

Issues related to inter-professional communication and communication with clients were discussed in depth. In site 2 the majority of midwives considered that the importance of good communication skills could not be over-estimated as the majority of complaints from women were related to some aspect of poor communication. Another commonly discussed topic was that of communication during labour, which had been the source of recent complaints. During exploration of the issues it became apparent that midwives in many of the groups often feared that women would make an unsafe decision, particularly during labour if the midwife engaged in discussions with her about the pros and cons of various aspects of care. This may lead to unfortunate consequences, and the midwife having to justify her actions. These two quotes illustrate some of the thinking:

"You get the situation whereby if you don't ask them then it is easy for you";

"We do give people choice but we are giving them the choice that we want them to make".

A further relevant point in this context related to the way 'traditional hierarchical' structures within the maternity service had led to certain patterns of communication developing that were now somewhat at odds with current trends towards a more woman-centred service. Midwives sometimes found it difficult to facilitate women's choices when medical staff were seen to be pressuring midwives to deliver care in a particular way. One supervisor commented:

"What has actually happened is that the medical establishment has scuttled into a larger huddle than they were in the first place".

Furthermore, one group of midwives discussed what they perceived as a further potential barrier to women's choice - the partner. One midwife indicating:

"I feel sorry that we are not allowed at least 15 minutes with the mother alone to get to know her better, you've got the husband there all of the time, they say they have decided against pain relief and the husband is there to enforce this".

A midwife from the same site, but attending a different research group was concerned about partners being used as interpreters:

"You are then relying on communicating through the husband and you know that he is only telling her a third of what you say to him".

However, on the other hand, another midwife paid particular attention to the need to make sure that fathers were more included in the whole process, and another commented:

"Midwives think that they are the most important person in this triangle. They have got to understand that they were not there at the conception, they are not carrying the child, what they are doing is trying to allow a family unit to develop and they should stand back from that."

One senior midwife described attempts at good communication as a process of trial and error:

"To some extent we have developed those skills by trial and error rather than having been taught them as such. It is a shame for mothers because you could have got it wrong with one mother, before you get it right",

and one of the lecturers (referring to midwives) commented that:

"what they need is more communication skills, to develop their communication skills, assertiveness as opposed to passivity, so that they can use it in the clinical area".

Communicating with parents on the issue of infant feeding was introduced into the discussions on several occasions in site 2 particularly, where there was a policy of not feeding newborn babies for eighteen hours (after initial feeding), unless they spontaneously fed. Midwives were rather divided on the wisdom of this, and thought the decision was probably based on research but they did not know what it was. Further discussions ensued relating to the relative advantages and disadvantages of breast versus bottle feeding, with midwives indicating a certain lack of confidence regarding advising mothers on such matters. There was not seen to be 'any definite advice that we need to give'.

(ii) Communication between midwives

Problems of communication between various groups of midwives were also identified in some measure in all study sites. Recent trends towards working within a system of rotation, was seen in some cases, to have heightened difficulties between hospital and community midwives, with each group being perceived by the other as 'doing their own thing and not understanding our role'. In one site, complaints were being made by mothers about community midwives not visiting the home postnatally. This annoyed the community midwives as they considered that the hospital midwives were at fault for not letting them know when mothers were being transferred home.

Another issue fairly commonly identified related to potential concerns about communication problems between midwives who had been trained in the 'traditional way' and those being trained initially to diploma or degree level. Particular concerns were raised in sites 2 and 3 relating to 'direct entry' midwives (some of whom had placements in these sites), and how they would relate to colleagues with very different backgrounds, experiences and knowledge bases.

(iii) Doctors' views on communication

Most of the doctors acknowledged that communication skills were important for all health professionals. One doctor commenting that:

"It would be no good to have someone who was expert in suturing perineums but had no communication skills".

One GP indicated that nearly all the complaints he heard from women related to poor communication between midwives when women were in labour - they frequently changed shifts without passing on information about the woman's care.

On the other hand, one GP considered that communication skills were overrated, but *'some things like anger management'* would be worth teaching. All the medical staff debated whether you can teach people to be pleasant or kind, without really reaching a conclusion, but it was generally felt that professionals can never have the right manner to suit all patients and there will always be 'likes and dislikes' amongst women that just need to be accepted.

(iv) Communication in 'specialist' areas

Most of the discussions with medical staff led on to the importance of midwives' communication skills in specific situations, such as when women or their babies were undergoing diagnostic or screening procedures, or when women were dealing with tragic situations such as the death of a baby or coming to terms with HIV/AIDS. Such issues were also discussed widely by all groups of midwives and managers/supervisors and lecturers.

The debate focused mainly around the extent to which all midwives needed the skills to communicate effectively with women and families in such situations, and when specialists help should be called upon. A diversity of views were put forward with one midwife indicating that:

"My view is that all midwives think they can counsel, but actually most of them can't".

On the other hand, a GP from the same study site commented:

"I do think that midwives are better at counselling than doctors because doctors are notoriously bad about being systematic about things".

On the whole, it was considered that all midwives needed the skills to give basic information, advice and support, and to be able to listen effectively to women on any topic that may arise in the course of practice. However, specialist input also needed to be available for any woman with specific needs, such as those experiencing trauma in the type of situations outlined above. However, the situation was generally considered, especially by midwives, to often become more complex in practice, with many of them feeling that although specialist input may be available in theory there were many occasions when the midwife was the only one there at a time of great need. One midwife indicated her concern in relation to dealing with bereavement:

"Once you have ticked all the boxes you know you can discharge the woman but you are dealing with somebody's grief".

There was general agreement that issues related to communication should be addressed through the package to facilitate midwives in inter-professional communication and providing woman-centred care. More specialist counselling skills were seen to be best addressed through specific courses for those who would be working within such areas.

2.4.4 Development of the educational package

(i) Level of package

Generally, midwives were in agreement that they would like to have an educational package developed for them that covered many of the issues outlined in this chapter, to facilitate their work within the current framework for practice. The need for the package to deal with both individual and contextual factors that may affect practice was identified. Running fairly consistently through the discussions outlined above, was the need for midwives to be provided with help to facilitate the integration of theory and practice. Those who had been in practice for a long time without undertaking regular formal study were particularly likely to make this point. Managers/supervisors, educationalists and doctors were broadly in agreement with midwives about the main issues that should be addressed through the package.

There was general agreement amongst everyone except doctors, that the package needed to be written so that midwives could use it to obtain academic credit. However, it was also considered important that the package would be accessible to those who had not studied for a long time, who may not feel able to start work towards accreditation immediately. The flexibility of an open learning package was considered to be beneficial by both managers and midwives. As well as academic accreditation, it was considered important that the package could be used for professional updating purposes. Midwives felt that peer/mentor and tutor support was essential to prevent feeling isolated and to maintain enthusiasm.

Doctors were less knowledgeable on the whole about the level of study midwives would require, although one GP thought it should be an entirely graduate profession. One consultant was very vociferous about the 'low level' he considered midwifery education to be at. He attributed this to the demise of the Central Midwives Board and the fact that consultants no longer were involved in giving an oral examination to midwives (he had taken part in this process).

Midwives generally had no problems in attending statutory refresher days but found it more difficult to complete longer courses such as degree and diploma courses due to work pressures and financial constraints. Part-time staff identified particular problems in this area. Managers thought that the refresher days were very difficult to accommodate timewise, and not necessarily the best way of meeting outstanding need. They welcomed the flexibility that they thought PREP would bring and hoped that the package would be useful in this context. The issue of how much study time managers would allow for midwives working through the package was difficult to predict, but most managers thought that they would like to offer midwives some form of support to enable them to take on a fuller role. However, local pressures on time and financial resources may inhibit this; although some managers indicated that money may become available when it is no longer used to fund the type of continuing education currently provided for some midwives in their service in respect of the statutory refresher requirement. Local educationalists thought the package potentially useful, and once it was developed they would consider whether they would find it beneficial to support midwives working through it. Some colleges were already developing their own materials which they would be using in the context of PREP.

With regard to the content and presentation of the package, the majority of midwives were quite sure that they would not be inclined to use a package that was heavily text-based 'like another textbook'. A range of educational materials were shown to midwives managers/supervisors and educationalists to inform the design of the package. Considerable information was obtained from this process which has been used to develop the package. The issues raised here in relation to use of the package and support required at local level have been fully addressed in The Learning Handbook that has been developed to accompany the package. It is interesting to note here that the original reticence expressed by several midwives to open learning techniques lessened when they saw some of the materials that had previously been produced.

Midwives generally were prepared to pay some or all of the cost of the package if it were available at a subsidised rate.

(ii) Multidisciplinary education

The issues regarding multidisciplinary education were not spontaneously discussed very often during the interviews. When the researchers introduced the topic, there was generally a rather ambivalent attitude towards the approach with the feeling that it was a good idea in theory but there would be many practical difficulties to be overcome. Clearly, there would need to be a strong input and commitment from all the relevant disciplines for such an approach to be effective. Developments are clearly being made in this area at the current time and the issues were discussed by the representatives of the relevant professional and statutory bodies in the interviews that were undertaken as part of this study (see Section 3).

There was general agreement however, that it would be important for those from a wide range of disciplines, as well as consumer representatives, to be involved in the development of the package. This was considered when the curriculum groups, authors, critical readers and midwife testers were being selected

2.5 Conclusions

In summary, the issues discussed were very similar in each of the study sites. On the whole, there were not obvious differences in the views expressed across the 3 sites, even though the sites differed in several ways as outlined at the beginning of this chapter. Where diverse views were expressed, this occurred as much within the same site, as across the 3 sites.

General practitioners were most likely to express diverse views from each other (although it has be noted that the number interviewed was rather small).

It is also interesting to note that there appeared to be quite a strong 'unit ethos' in relation to the views expressed by midwives about the way midwifery ought to be practised and the factors that facilitated or hindered such a process. The major difference that occurred was in relation to community and hospital based midwives. They did not actually raise different issues or have very diverse views on key issues, but they tended to give the impression of being two rather distinct groups, that did not have a great deal of confidence in their counterparts. For example, on several occasions hospital midwives indicated that community midwives delivery suite skills were rather poor 'they are no good...' and community midwives drew attention to some hospital midwives lack of understanding or interest in women from a range of backgrounds. Recent rotation exercises seemed to have exacerbated, rather than allayed concerns about more integrated working.

In the groups where both community and hospital midwives were interviewed at the same time, the tension seemed to exist still, and initially they were wary of each other when giving their views. However, as the interviews proceeded they appeared more willing to openly challenge each other and listen to the point of view put by the 'other side'. This principle also seemed to hold good on the occasions when midwives from the same work setting did not agree with a point made by a colleague. In some cases, where clear differences in view or philosophy existed, it was obvious that discussions had hitherto not been held between the midwives concerned, but this started to happen in some of the group interviews - a point which may be worth noting for future developments. A strategy that seemed to be fairly commonly used for dealing with potentially conflictual situations between midwives in research groups was humour. Midwives also indicated that they commonly used humour in their interactions with women, as they felt it diffused potentially difficult situations and 'cheered mothers up' They did not note any difficulties or concerns in relation to use of humour (such as lack of agreement on what is amusing).

Midwives and managers/supervisors discussed very similar issues, often indicating very similar views. However, they were often under the impression that they would have been attacked by the 'other group' when they were interviewed, and were keen to know what the others had said in their interviews. Where differences occurred, they tended to relate to ways of dealing with outstanding issues, such as resourcing issues in relation to the systems of midwifery care that would be operationalised (e.g. the potential organisation of team midwifery). There was less disagreement about the actual philosophy of care that interviewees believed ought to underpin midwifery. Generally, the move towards a more woman-centred service was supported, although not very often in such explicit terms.

SECTION 3 INTERVIEWS WITH NATIONAL ORGANISATIONS INVOLVED IN THE DEVELOPMENT OF THE MATERNITY SERVICE

Interviews were undertaken with representatives of national organisations involved in the development of the maternity service, particularly the continuing education of professional staff. One representative from each of the following organisations was interviewed:

- United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC),
- English National Board for Nursing, Midwifery and Health Visiting (ENB),
- Department of Health (DOH),
- Royal College of Midwives (RCM),
- Royal College of Obstetricians and Gynaecologists (RCOG),
- Royal College of General Practitioners (RCGP).

All interviews were audio-recorded and tapes fully transcribed for analysis purposes.

A semi-structured topic guide was used. The key issues covered included:

- the background of the organisational structure and the role of the interviewee within that structure,
- key issues regarding educational policy for the development of the maternity service,
- role and responsibilities of midwives,
- Changing Childbirth,
- issues related to the assessment of quality of care,
- continuing educational and training needs of midwives - including development of educational package for this project.

The summary below provides an overview of the key issues discussed particularly in relation to the role and responsibilities of professionals working within the maternity service and the continuing education and training need of those professionals, particularly midwives.

3.1 Background

All the representatives interviewed had key responsibility for educational policy in their organisations, with the exception of the RCGP where there was not one post with specific responsibility in this area. The representative interviewed was a member of RCGP Council, with particular expertise and interest in maternity care.

All the organisations indicated a fairly clear focus for future developments in education, particularly the midwifery statutory organisations. Plans had been made, and were starting to be implemented to ensure that education meets the quality and standards that have been determined. The ENB and UKCC representatives both clearly outlined their respective roles in relation to the development, implementation and monitoring of educational policy and initiatives.

In summary the UKCC's main functions are:

- to maintain the professional register for nurses, midwives and health visitors,
- to establish and improve standards of education and training,
- to establish and improve standards of professional conduct in order to protect the public from unsafe practitioners.

At the time of interviewing there was an elected midwife on the Council who was Chairperson of the Midwifery Committee. Changes to the Council structure of the UKCC have subsequently occurred, but its statutory remit remains the same.

With regard to midwifery, the ENB has a remit to ensure that the standards which have been referred to above, that have been incorporated into the Nurses, Midwives and Health Visitors Act, the Midwives Rules and the Midwives Code of Practice are met. The Board is responsible for ensuring the quality of midwifery education and making sure that programmes of education equip the workforce to meet changing demands. There is a Director of Midwifery Education and Practice who is supported by an Assistant Director and a group of generic education officers who have specialist expertise in midwifery.

3.1.1 Provision of continuing education and training

The DOH representative discussed the importance of the future role of Regional Education and Development Groups (REDG) in relation to advising on the education plans that the new Consortia will put forward. The Consortia will hold the budget for Non-medical Education and Training and will contract with education providers. Key members of the Consortia will include NHS purchasers and providers of health care, non NHS health care providers and GP's. Plans were still at an early stage when the interviews were carried out but the importance of ensuring high quality education within the new system was identified. The REDG or a sub-group will have annual meetings with each major education provider with whom contracts are placed, to discuss future plans, improvements in contracting relationships and the implications of changes in the education sector for health service provision.

The future plans for funding the education and training of maternity service staff were discussed by all those interviewed, with a general view emerging of the need for a balance between central and local responsibility for funding initiatives. However, due to the current state of flux within the health and education services, it was not considered possible to make any more specific recommendations at this stage.

The RCM placed particular emphasis on the need to ensure that the education provided under the new system outlined above will meet the needs of the midwifery profession. It recognised the importance of its own input in this respect.

The RCOG indicated that a key development for the future would be the education and training of junior doctors for future responsibilities within the maternity service. In this respect, the importance of the involvement of midwives and GP's, as well as obstetricians was recognised, as was the significance of more emphasis on community based training.

The RCGP recognised the need for an increase in the experience of doctors in community settings and 'normal' obstetrics. In line with this, plans were being made to increase the practical component of the training for GP's. The RCGP representative also indicated that he considered midwives will need more community based training if they are to effectively facilitate woman-centred care in line with Changing Childbirth.

3.1.2 Educational and training initiatives

With regard to continuing education and training, all the organisations involved in midwifery provision indicated the importance of PREP and the consequent end of the statutory refresher requirement for midwives in its current form. The main consequence of this was seen to be in relation to midwives being more accountable on an individual basis for ensuring their competence to practise. All the representatives of the midwifery profession interviewed indicated their general agreement with the principles underpinning PREP but were aware of the need to ensure that midwives received the support necessary to fulfil their requirements under PREP.

The DOH representative indicated the potential importance of the role of supervision in ensuring high standards of practice. The UKCC was in the process of preparing new guidelines on supervision at the time the interviews were undertaken. In relation to the monitoring of PREP, the UKCC recognised the need to keep the procedures under constant review in order to ensure the highest standards of care were provided to the public.

Both the RCM and the ENB indicated their continuing involvement in educational and training initiatives that would assist midwives in undertaking their full role within the changing maternity service. For example, the RCM has been involved in identifying the continuing education needs of midwives and has recently developed initiatives aimed at facilitating woman-centred care and providing optimum care for the 'disadvantaged' client. Annual meetings are held between the Education Advisory Group and the Heads of Maternity Services to encourage constructive working.

The ENB were involved in providing a post-registration initiative in relation to Changing Childbirth. Under this initiative, an educational resource pack has recently been published for use by the profession, and eight post-registration modules specifically focused on taking midwifery practice forward within the Higher Award have also been developed.

The RCOG indicated the need for all those working in a medical capacity in obstetrics and gynaecology below consultant level to show evidence of continuing professional development in terms of a certain number of credit points being gained over a 5 year period. Points can be amassed in a variety of ways including attendance at specific courses or meetings that are run or approved by the College at national and regional level. The RCGP drew particular attention to the need for more multidisciplinary education and training initiatives The professional bodies were seen to have a key role in this respect, and the need for better mechanisms for communication between the RCGP, RCM and RCOG was identified. There is a standing relationship between the 3 Colleges, whereby twice yearly meetings are held where educational matters can be discussed but there was still considered to be room for further developments.

There was general agreement that multidisciplinary education was to be encouraged, but an underlying concern was voiced by several of the interviewees that the 'other' organisations were not pulling together to facilitate this. Some examples of good practice in this area were cited by the RCGP RCOG and DOH. The two medical organisations drew attention to a scheme being run in one region where obstetric senior house officers spent sometime training in the community with GP's. The need to involve midwives in such schemes was indicated by both the RCGP and RCOG representatives.

The RCOG was keen to take forward plans for multidisciplinary education for obstetricians, GP's and midwives. Some recent work had been undertaken with the ENB in this respect, which both organisations spontaneously discussed and supported in principle, but the importance of adequate time for the preparation of such initiatives was highlighted by the ENB representative. The DOH representative drew attention to the work that has been undertaken, particularly in the last 5 or 6 years to facilitate multidisciplinary education and working. A key issue that was seen to require further work was in relation to persuading consultants to spend less time working with women experiencing normal pregnancies/childbirth, which would allow more time for teaching in a multidisciplinary context.

Overall, the picture is one of commitment from all the relevant bodies to the continuing education of the professions, with the midwifery organisations having the most clearly outlined mechanisms in place for implementing and monitoring the impact of educational initiatives. However, the need for further developments in relation to the channels of communication between the various organisations was apparent, if the potential for multidisciplinary education and working is to be effectively utilised. None of the professional bodies considered that they had adequate input into the decision making processes of the other organisations, despite senior level links in all cases, with cross council representation occurring in several cases.

It is interesting to note that the RCM, RCOG and RCGP meet with purchasers and users groups to discuss the ways in which professionals might corporately look at the services provided. Various documents relating to standards regarding maternity care have been produced as a result of this process. Such forums may continue to be of use in promoting constructive working in relation to a broad range of issues related to maternity service, provisions including educational initiatives.

3.2 Role and Responsibilities of Midwives

The issue of the scope of practice of midwives was widely discussed by all those interviewed. There was a general consensus that midwives had a key role to play in the provision of maternity care, particularly in 'low risk' cases. The representatives of the midwifery organisations indicated that there had been some erosion of the midwives role over the past decades as there had an increased impetus towards birth in hospital. The need to pay careful attention to the working conditions, grading and pay structures of the midwifery profession was addressed by two of the midwifery profession representatives in relation to the 're-empowering' of midwives.

The issues of 'autonomous' and 'independent' practice in relation to midwifery were discussed at length. There was general agreement that legislation allows for midwives to practise without recourse to any other professional in low risk cases, and that they are accountable in law for their own actions. However, the representatives of the medical profession interviewed stressed the importance of the 'team' approach to care where both midwives and doctors would remain involved in care provision for the majority of women. This was not seen as encouraging unnecessary overlap in role but as facilitating holistic care. The RCGP representative indicated that the provision of antenatal and postnatal care were part of the core responsibilities of the GP, and medical and midwifery responsibilities were not seen as mutually exclusive in this respect. It was acknowledged that this was a controversial area which was not likely to be easy to resolve. Intrapartum care was viewed as only a very minor part of a GP's role, about which the RCGP preferred not to make a formal statement (although subsequently a joint statement has been issued by the RCM/RCGP - see Chapter 8).

The RCOG representative also supported the 'teamwork approach' to maternity care. This did not mean that all women had to see every member of that team but that each member of the team needed to be fully aware of the role and skills of the other team members and be able to communicate and refer effectively in the best interests of the woman and baby. It was not envisaged that any woman would have all her care from medical members of the team, as even in high risk cases the midwife would provide a key role in care provision. However, there could in theory be occasions when the midwife provided all the care to low risk women. This was not, however, viewed as ideal as it might lead to undue anxiety when women were referred to doctors - as they could easily be seen as the ones called in to deal with problems.

The midwifery representatives were all aware of the need for good inter-professional working, but generally took the view that it was not necessary or desirable to have medical involvement in low risk cases as a matter of routine. However, midwives were seen as perpetuating this practice by not having sufficient confidence to make decisions, which were often within the remit of the midwife, without medical backup.

3.3 Changing Childbirth and the Provision of 'Good' Care

3.3.1 Implementation of Changing Childbirth

The RCOG, ENB UKCC and RCM had all issued responses in relation to Changing Childbirth which outlined the position of the respective organisations regarding the report. The tenor of these responses has been outlined earlier in Chapter 1. The discussions focused mostly around the issues of concern to each of the organisations involved in the interviews. The midwifery organisations generally supported the concept of woman-centred care. The resourcing issues in relation to midwifery were a matter of concern to them all. Recent changes to staffing and grading structures were seen to have led to many difficulties in relation to providing an optimum service and in leading to problems of low morale within the profession. However, the need for midwives to have a more flexible attitude to the way their work was organised was also pointed out by the representatives of two of the organisations.

The ENB representative took the view that the implementation of Changing Childbirth would lead to several advantages. For example, the very considerable knowledge and skills of midwives would be more effectively utilised in the best interests of service users, continuity of care would be enhanced, with less potential for conflicting advice being given, and if the system were to work as anticipated there would be increased job satisfaction for midwives, which would be likely to lead ultimately to lower staff turnover and a 'value added' maternity service.

The RCM supported the move to a more woman-centred service but also drew attention to the need to ensure that centrally driven changes were not imposed on women. In this respect, the importance of making sure that services were appropriate and accessible to the needs of the local population was stressed.

The RCOG and RCGP discussed the importance of monitoring the effects of the implementation of Changing Childbirth on service provision.

3.3.2 Evaluation of the implementation of Changing Childbirth

The issue of defining 'quality care' was considered complex by all those interviewed. The medical representatives indicated that Changing Childbirth may not have any effect on 'hard outcomes' such as perinatal mortality or episiotomy trauma but was more likely to affect 'softer' issues such as maternal satisfaction, feelings of control and continuity of care. These 'softer' outcomes were also considered to be associated with 'quality' care. All the organisations considered that it would be important for the effects of Changing Childbirth to be evaluated but there was no clear consensus as to how this should best be done (or by whom), although there seemed to be general agreement that work should be undertaken both nationally and locally in this respect.

The ENB appeared to consider it had the most responsibility in this regard which has been recognised by the DOH Changing Childbirth Implementation Team. By the time the interviews were undertaken, the ENB had already collected national data on the extent to which the indicators of success were being implemented. Regular Midwifery Practice Surveys are carried out by the ENB, which in the future will include issues related to the implementation of Changing Childbirth.

3.3.3 'Good' midwifery care

There was broad agreement regarding perceptions of what makes a 'good midwife'. The need for excellent communication skills, including the ability to listen and empathise was considered a key priority. Having a good knowledge base was also identified as very important. The UKCC representative indicated the importance of the knowledge base being derived not only from midwifery knowledge, but also from nursing, medical, paramedical, behavioural science and social science sources. The need for midwives to be able to have the skills to constantly access research findings and be able to critique studies in relation to their potential use in practice was also stressed. The importance of good leadership and change management skills was also considered a priority as a lack of skills in these areas in the past was perceived to have led to difficulties in midwives *'holding their own in the political arena'*.

The ENB representative indicated the importance of midwives being caring, sensitive, empathetic, and having the ability to use their knowledge and skills in the best interests of the mother. In this context, the ability to know how and when to best utilise the skills of colleagues was also stressed. The need for midwives to be able and willing to facilitate women's choices was seen as vital in the light of the implementation of Changing Childbirth. The effective facilitation of choice was seen as requiring particular understanding and negotiation skills, especially in situations when the mother may initially opt for an option that does not appear to be safe for the baby. The RCGP, DOH and RCM representatives also indicated the importance of the attributes and skills outlined above, and drew particular attention to the need for midwives to be aware of the broader context in which they are working, to be effective team workers, and to have the skills to negotiate their role effectively.

3.4 Continuing Education Needs of Midwives and the Development of the Educational Package

Many of the issues discussed above were considered to be important in relation to the continuing education and training needs of midwives - communication, research and leadership skills were mentioned by all those interviewed. The skills needed to facilitate critical analysis of situations and to be able to effectively facilitate woman-centred care were considered to be important for all midwives. In this context, the importance of adequate education in a broad range of issues was identified, including the way the individual interacts with the environment, contextual issues, and the synthesis of a good knowledge base - drawing on clinical experience and research-based information.

All those interviewed agreed that research should play an important role in informing midwifery practice. There was a general consensus of opinion that research is not really used appropriately by the majority of the profession. Traditional midwifery education programmes were not seen as facilitating the effective use of research by midwives, whereas medical education had put much more emphasis on underpinning practice with research. On the positive side recent government initiatives such as the NHS Research and Development Strategy were seen as encouraging more effective use of research in the health service generally. The DOH and RCOG representatives drew particular attention to the importance of mutidisciplinary research, and midwives were seen to have an important role to play in this respect. The importance of education programmes in facilitating the midwifery profession in becoming more confident to be 'research minded' was stressed by the interviewees.

In addition, the ENB representative drew particular attention to the need for continuing education programmes to help midwives to empower themselves, particularly in relation to communication with the medical profession. The UKCC representative indicated the key importance for midwifery education to assist midwives in *"pushing back the boundaries of the profession through research and having a broad and deep knowledge of professional discipline"*.

Clinical skills were not frequently discussed in relation to continuing educational need. The general view appeared to be that midwives are highly skilled in this area, and when further education and/or experience was required it was best obtained at local level, in line with identified need.

The representatives of the midwifery profession interviewed all drew attention to the need for the package to be developed in a way that it would be possible for midwives to gain academic accreditation towards diploma and/or degree level study. However, the importance of the package being accessible to those who had not studied for sometime, who may initially be daunted by the prospect of studying for academic credit was also indicated. It was also considered important that the package should be flexible in relation to PREP.

There was general agreement that the authors of the package should be drawn from a range of backgrounds relevant to the provision of maternity care The importance of midwives with a range of skills and expertise (clinical practice management, research, education) was stressed, as well input from the medical profession and social scientists (with relevant expertise - possibly, but not necessarily midwives).

CHAPTER 7: CONSUMER RESULTS

Results have been presented in 5 sections:

SECTION 1 BACKGROUND INFORMATION

SECTION 2 ANTENATAL CARE PROVISION

SECTION 3 CARE DURING LABOUR AND DELIVERY

SECTION 4 POSTNATAL CARE PROVISION

SECTION 5 SATISFACTION WITH CARE PROVISION

SECTION 1 BACKGROUND INFORMATION

All mothers who were approached to participate in the study agreed to do so, except one who indicated that she did not have time.

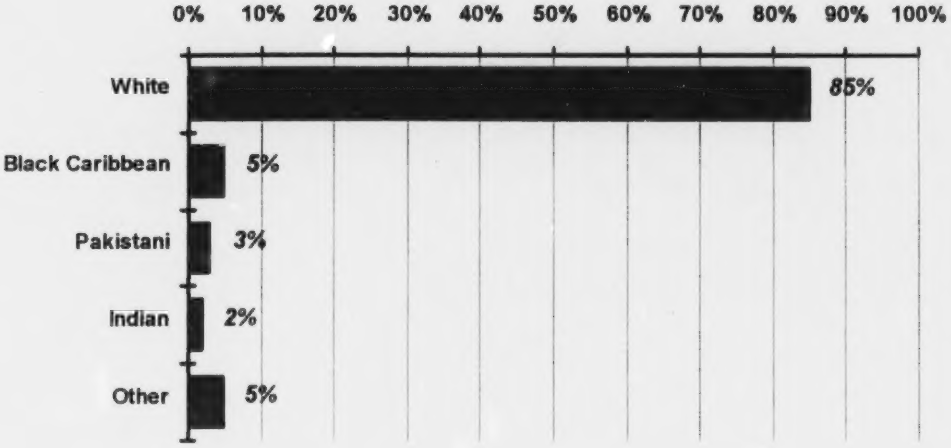
The total number of mothers included in the sample was 115:

Case study 1 n = 52.

Case study 2 n = 63.

The mean age of the mothers was 27 years .

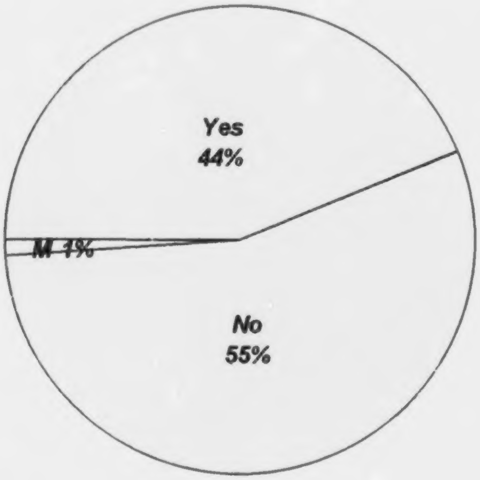
Figure 7.1: Ethnic background of mothers in sample (n=115)



The Ethnic background of the mothers in the sample broadly reflected that of the local population in each of the case study sites. There was a difference regarding ethnic breakdown between the two sites with most of the 'non-white' mothers from case study site 2.

Mothers were asked to indicate whether they had a job (mothers on maternity leave were categorised as employed).

Figure 7 2: Mothers' employment status (n=115)



The social class background of the mother and her partner (where applicable) was determined on the basis of the registrar general classification.

For the purposes of analyses, the social class background of each respondent was determined in terms of the highest classification of the mother or her partner as applicable.

The social class background of the sample respondents broadly reflected the social class breakdown of the local populations in site 1 and site 2.

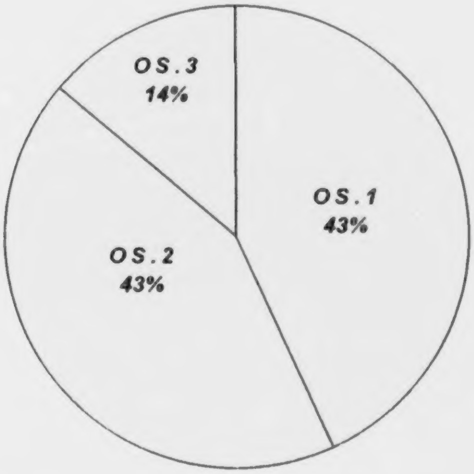
Due to the limited sample size, it was not appropriate to analyse variables by each of the five registrar general classifications. Therefore, three summary 'occupational status' classifications were used:

Occupational status 1 = registrar general classification 1, 2 and 3 non-manual.

Occupational status 2 = registrar general classification 3 manual, 4 and 5.

Occupational status 3 = unemployed respondents

Figure 7.3: Occupational status (n=115) *O.S. = Occupational Status*

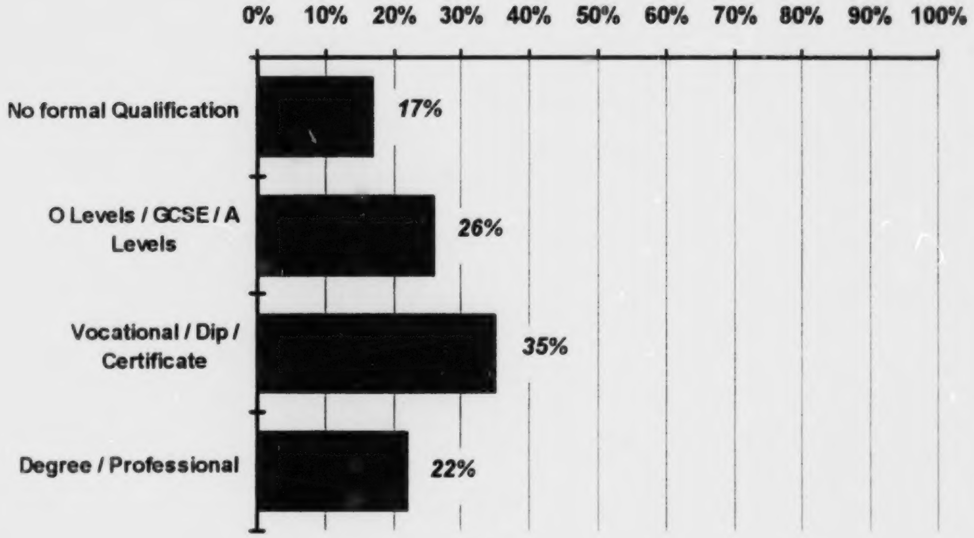


Mothers were asked to indicate the highest level of educational attainment achieved. The categories that were used in the questionnaire included:

No formal qualification, O Levels/GCSE, A Levels, higher education certificate (certificate), diploma (dip), first degree, higher degree, professional qualification (specified); other (specified).

For the purposes of further analyses the categories were collapsed as outlined in Figure 7.4.

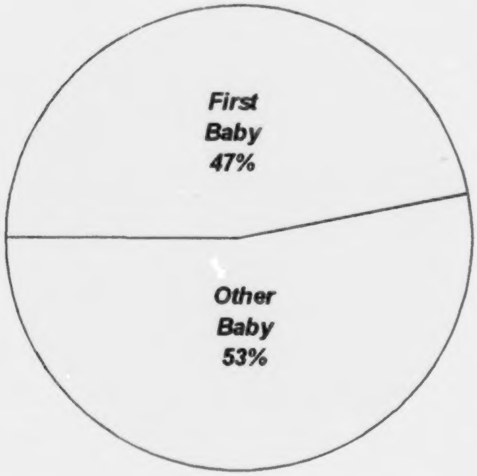
Figure 7.4: Mothers' education level (n=115).



There was a significant difference in the educational level of mothers in the two sites. Site 2 had more mothers at both the higher and lower ends of the scale(p=.004).

Mothers were asked to indicate whether this was their first or subsequent baby. Where appropriate the number of previous babies was recorded, (including still born or died after 24 weeks).

Figure 7.5: First or subsequent baby (n=115)



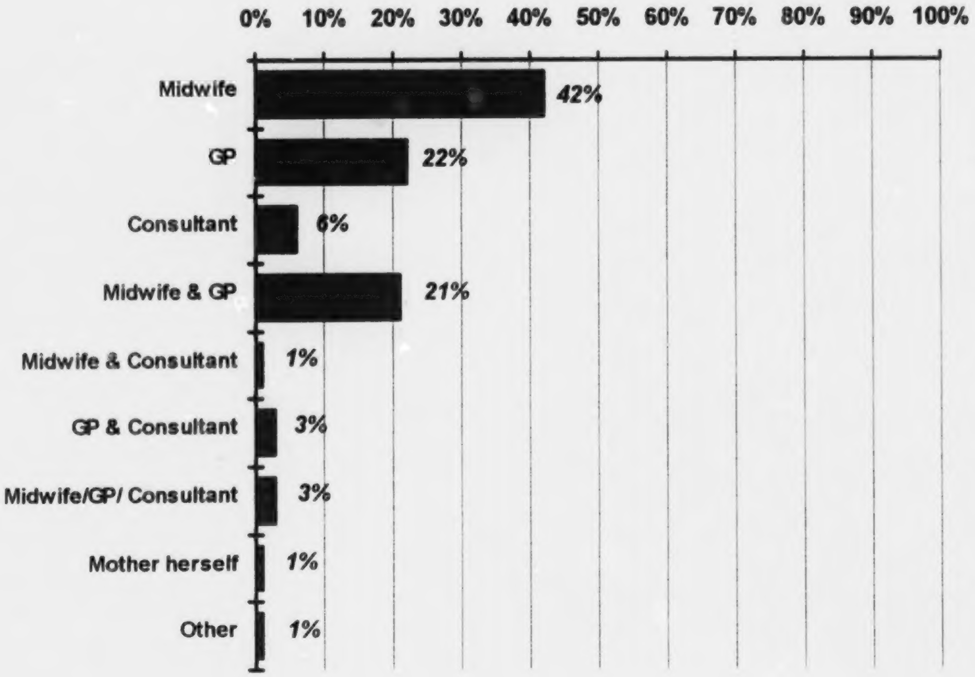
For analyses purposes mothers were classified as either having their first baby or subsequent baby.

Mothers were asked where their baby was delivered.

The vast majority of babies were delivered in an NHS hospital. Two mothers had a home birth. Ten mothers were provided with care under the domino scheme.

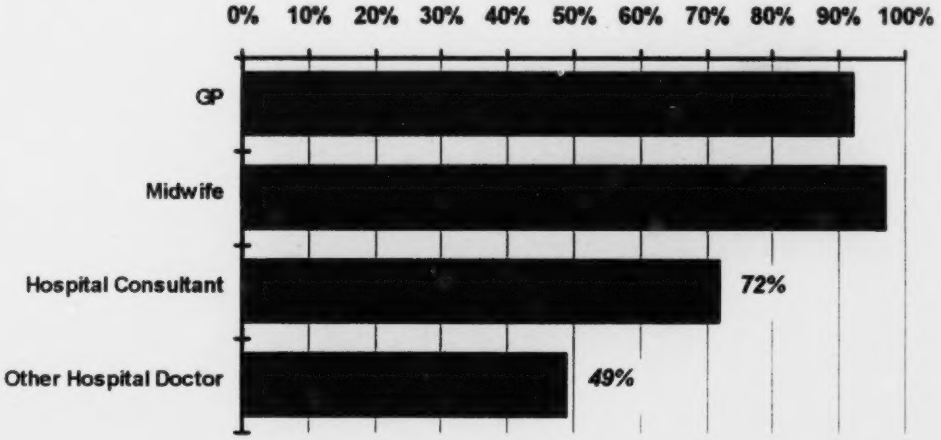
Mothers were asked to indicate who was overall responsible for their care antenatally

Figure 7.6: Professionals overall responsible for care antenatally (n=115)



Mothers were asked which of the following professionals they saw during pregnancy.

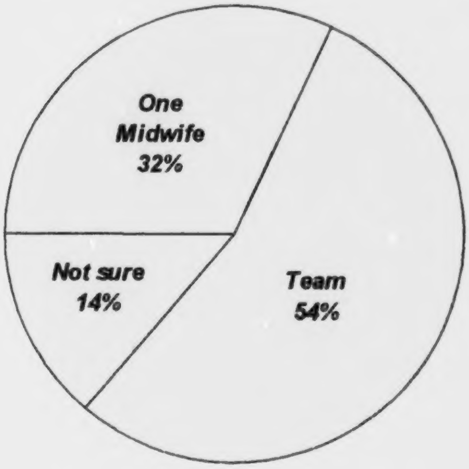
Figure 7. 7: Professionals seen during pregnancy (n=115)



Twenty eight percent of mothers reported that they did not see a consultant during pregnancy, and twenty five percent did not see any hospital doctor. One mother was seen by a GP only. Ten mothers were seen by a midwife only, and one by a consultant only.

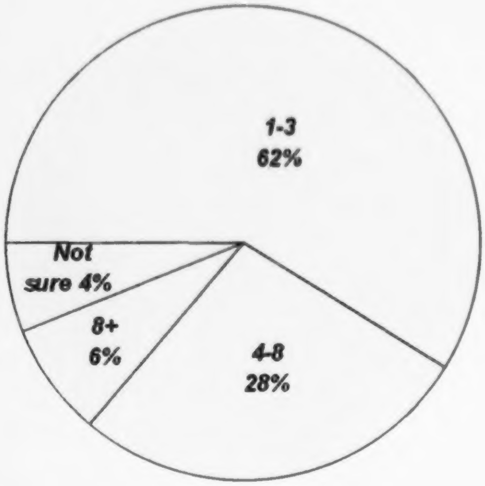
Mothers were asked whether they knew a particular midwife, or a team of midwives who were responsible for their care.

Figure 7.8: Team or individual midwifery care (n=115)



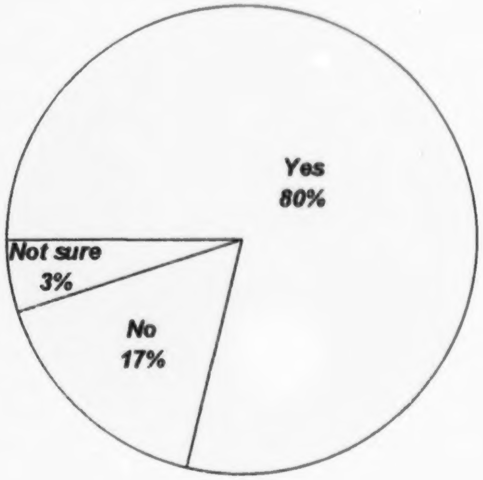
Mothers were asked whether they could estimate how many different midwives they saw during pregnancy.

Figure 7.9: Number of midwives seen during pregnancy (n=115)



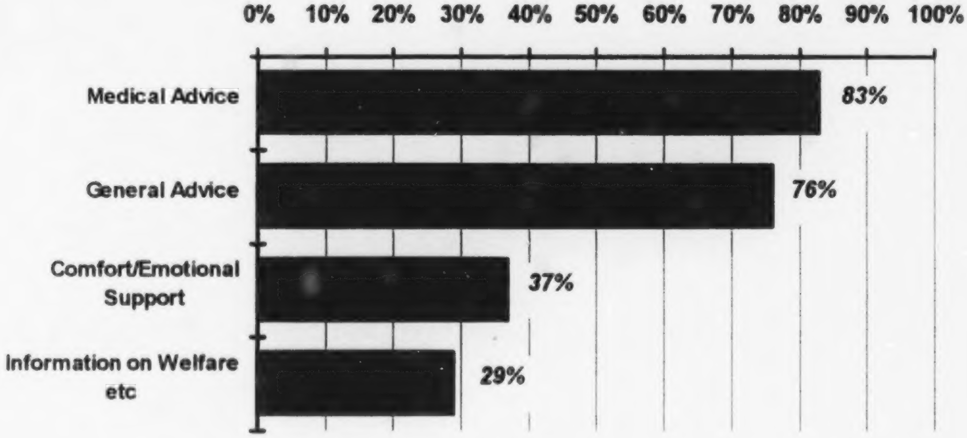
Mothers were asked whether any of the midwife/s got to know them and remembered them from one visit to the next.

Figure 7.10: Midwives remembered mother from one visit to the next (n=115)



Mothers were asked whether they felt they had enough opportunity to talk to a health professional/s during pregnancy for the various issues outlined below.

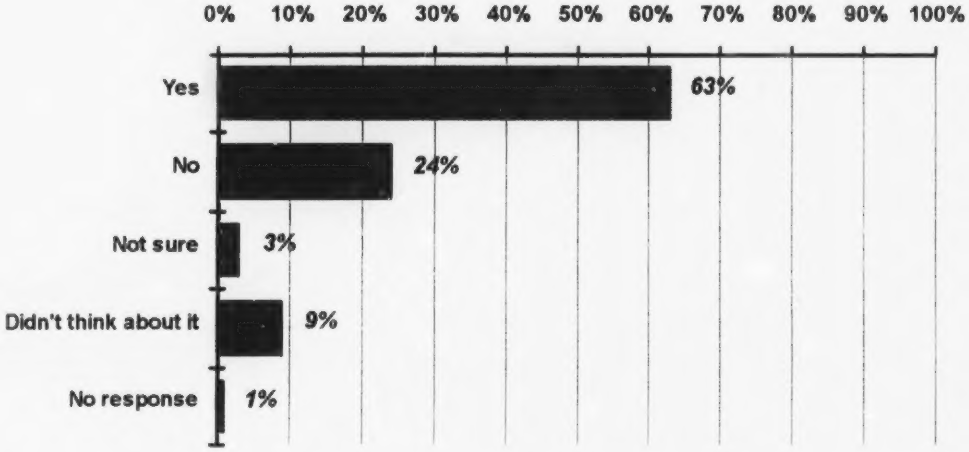
Figure 7.11: Enough opportunity to talk to health professionals (n=115) (yes)



Of those who considered they had enough opportunity to talk to health professionals for the issues outlined above, the majority indicated they talked to the midwife. A combination of midwife/GP was the second most commonly mentioned group.

Mothers were asked whether they considered they had enough opportunity to discuss their choices and wishes for their pregnancy and the birth.

Figure 7.12: Enough opportunity to discuss choices and wishes for pregnancy and birth (n=115)



The vast majority (71%) of those who considered they did have enough opportunity to discuss their choices and wishes indicated that they did so with the midwife.

Mothers who did not consider they had sufficient opportunity to discuss their choices and wishes were asked to indicate why this was so.

Approximately one in five mothers commented. Comments focused mainly around not being asked about the type of care they would like, particularly with regard to the place of birth. It was just assumed that the baby would be born in hospital. The midwife was seen to be just as likely as the GP not to facilitate the discussion about place of birth.

A sample of quotes from mothers concerning the place of birth show the type of problems that mothers reported:

"They just told me"

"No options offered"

"GP and midwife did not talk about it"

"Saw GP who stated that I did not need a home birth".

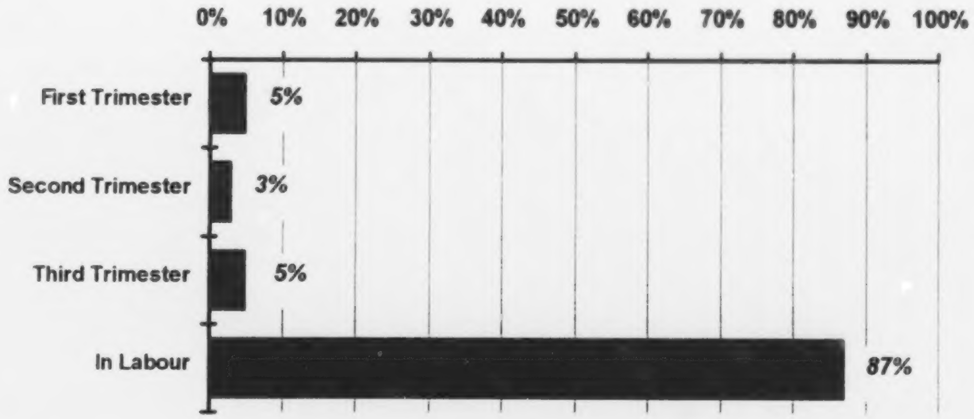
SECTION 3 INTRAPARTUM CARE

The majority of mothers were looked after by a midwife during labour and delivery. Around half the sample were cared for jointly by a midwife and a hospital doctor. Only one woman was cared for by a midwife and GP during delivery.

First time mothers were significantly more likely to have a midwife and a doctor present at the delivery(p=.001).

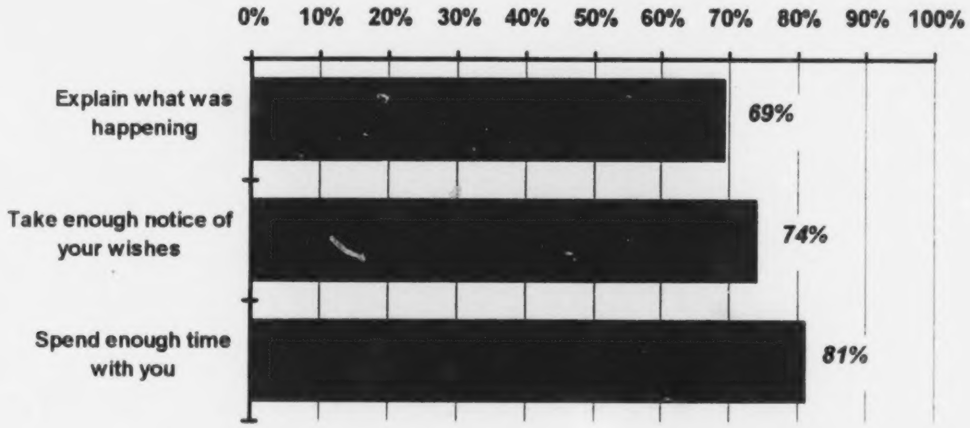
Mothers were asked when they first met the midwife/s who looked after them in labour and delivery.

Figure 7.13: When mothers first met the midwife/s who cared for them during labour and delivery (n=115).



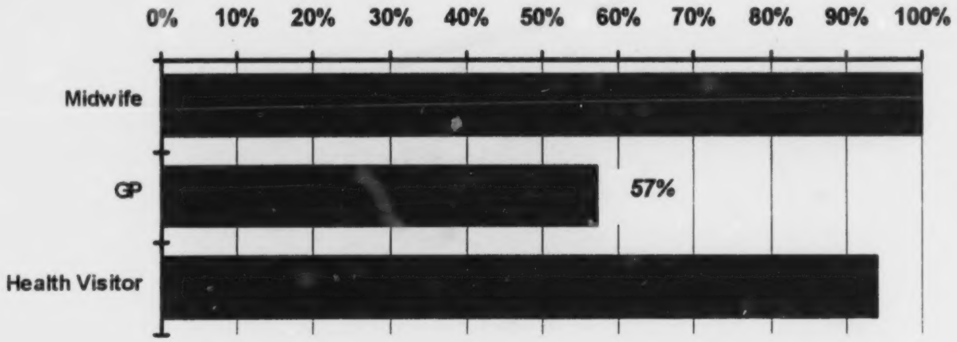
Mothers were asked whether the midwives/doctors who looked after them during labour and delivery explained enough about what was happening, took enough notice of their views and wishes and spent enough time with them.

Figure 7.14: Percentage of mothers who indicated professionals ***always*** *met needs (n=115)*



Mothers were asked whether they were visited postnatally at home by professionals.

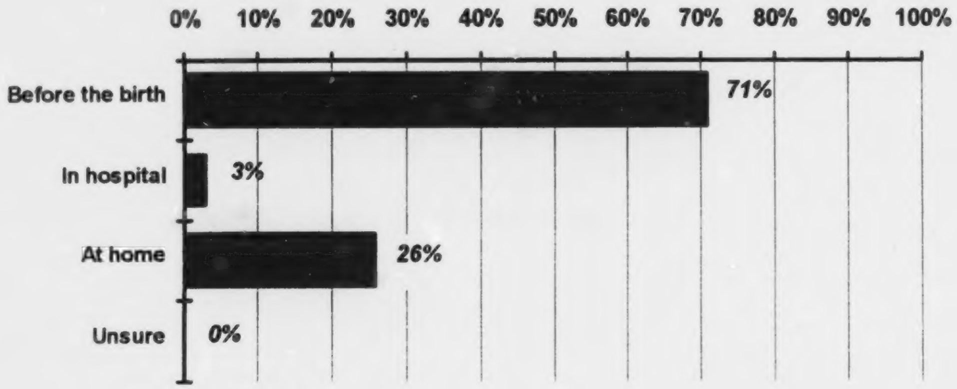
Figure 7.15: Percentage of mothers who were visited by professionals postnatally at home (n=115)



The majority of mothers were visited by up to 3 midwives at home in the postnatal period. None of the mothers was only seen by one midwife.

Mothers were asked when they first met the midwife/s who visited them at home postnatally.

Figure 7.16: When mothers first met the midwife/s who visited them at home (n=115)



SATISFACTION WITH CARE PROVISION

Mothers were asked to indicate how satisfied they were with the care they received specifically from midwives throughout their pregnancy, birth and the postnatal period.

5 point scale (1= not satisfied, 5= very satisfied)

Table 7.1: Satisfaction with midwifery care (n=115)

Satisfaction	%
5 Very Satisfied	55
4	31
3	9
2	2
1 Not satisfied	1
Missing	2
Total	100

Mothers were asked whether midwives did anything that was particularly helpful during pregnancy, the birth and the postnatal period,

Comments relating to the antenatal period were made by 13% of the mothers. Issues focused around: reassurance, particularly about the birth process, midwives willingness to share personal experiences, to explain at length answers to mother's questions, to be sensitive to the needs of the individual, and to pass on information about the mother's history and choices to other midwives.

Fifteen percent of mothers commented specifically on care during labour. The important issues identified in relation to labour and delivery included respecting the mother's wishes and doing everything the mother requested, being positive and clear with instructions, giving good advice regarding pain relief, midwives sharing their own experiences, and the midwife staying in the room whilst the baby was being born.

Comments specifically related to the postnatal period were made by 20% of mothers and related mainly to midwives visiting the home regularly, listening to the mother's concerns and giving advice and reassurance about the care of the baby.

Twenty six percent of women commented on their care in general, with 7% specifically mentioning the importance of midwives support with breastfeeding. Thirteen percent of the comments were in relation to the demeanour of midwives - not being rushed, having a positive caring attitude towards women, being friendly and giving the impression of 'loving their job'.

The following quotes show the importance to women of the midwives involvement in their care:

"My midwife managed to get my husband back from Ireland".

"She got to know the family unit and phoned to find out how I was".

Mothers were also asked whether a midwife/s did anything that was particularly unhelpful throughout pregnancy, the birth and the postnatal period.

Seven percent of the mothers commented specifically on the antenatal period. Issues generally focused around midwives not listening to mother's concerns and not giving adequate information. One mother commented:

"The reason for the blood test was explained but they did not give me the results, which made me worry".

Seventeen percent of the sample commented specifically on labour and delivery. Midwives reportedly ignored requests for pain relief and did not fully explain issues, such as the need for perineal suturing to mothers. Conflicting advice was considered to be a problem for a small number.

These quotes from mothers exemplify the comments that were made:

"When in pain the midwife told me to stop moaning and kept telling me to shut up".

"I wanted an epidural and was offered one by the first midwife, but the second did not approve".

Seventeen percent of mothers also commented on the postnatal period, where most of the complaints related to a perceived lack of interest by the midwives in the mother's concerns about the baby, or conflicting advice being given by different midwives, particularly regarding infant feeding.

Three mothers were concerned about a breach of confidentiality - they all worked in the same place and the midwife had told them all that the others were pregnant without permission to do so.

Finally in relation to 'helpfulness' issues, mothers were asked whether a midwife/s could have done anything to be more helpful throughout the pregnancy, the birth and the postnatal period.

Forty four percent of mothers commented. Comments related mostly to the issues already discussed above, however, the inconvenience of long waiting times in hospital antenatal clinics before being seen by a midwife was also stressed. Continuity of care was mentioned as something that would have been helpful to mothers. Two mothers summed up the situation thus:

"To see the same midwife antenatally and postnatally would stop me from having to repeat the same story".

"I would have liked to meet the midwife who delivered me beforehand".

It is interesting to note that although the majority of comments were made in relation to midwives being 'helpful', several mothers indicated areas where midwives had been both helpful and unhelpful.

Finally, mothers were asked "What do you consider makes a good midwife?"

Ninety six percent of mothers commented. Key themes emerged when women were asked to describe the characteristics of a 'good' midwife. These included: knowledgeable; a good listener; approachable; friendly and pleasant; non-critical and non-judgmental; has time and is a good communicator.

Other comments made by a small number of mothers focused around midwives being personally interested in their individual circumstances, and being "flexible" with advice, particularly about feeding. Common sense was considered by a small number to be important, as was the ability to build up a good rapport with the father as well as the mother. Midwives' ability to be aware of the needs of women from different cultures was identified by a small number of mothers.

CHAPTER 8: DISCUSSION AND CONCLUSIONS

In this chapter the key findings from the study have been drawn together and discussed in relation to relevant findings from the literature, and the potential implications of the findings for education and practice have been identified. The findings have been discussed in the following sections:

SECTION 1	**BACKGROUND OF PRACTISING MIDWIVES IN ENGLAND**
SECTION 2	**PROVISION OF MATERNITY CARE**
SECTION 3	**QUALITY ISSUES**
SECTION 4	**ASPECTS OF CARE PROVIDED BY MIDWIVES**
SECTION 5	**CONTINUING EDUCATION NEEDS OF MIDWIVES**
SECTION 6	**EVALUATION OF MIDWIFERY CARE**
SECTION 7	**CONCLUSIONS**

SECTION 1 BACKGROUND OF PRACTISING MIDWIVES IN ENGLAND

1.1 Qualifications and Education

Over ninety percent of the midwife sample were registered general nurses. The majority of the sample did not have any other relevant qualifications apart from basic nursing and midwifery education, although the ENB 997 or 998 qualification (teaching and assessing in clinical practice) was held by over 40% of midwives, mostly G grades.

The picture regarding the background of midwives is likely to substantially change over time with the qualification of more midwives who will not have a nursing qualification. Interestingly, just under forty percent of midwives in the national sample, and ten percent of supervisors indicated they considered it important for midwives to be trained nurses.

However, when the issue of midwifery education was discussed during the case study interviews, concerns were raised about the competence of midwives who were not trained as nurses, to care for women with medical conditions, such as heart disease, diabetes and asthma. As the situation was new to many midwives they did not have much experience to draw on in this respect but those who were in the places where midwives with non-nursing backgrounds were being educated had clearly been giving the matter some thought. The importance of the midwives role in caring for women during **normal** pregnancy/childbirth was acknowledged but the need for midwives to also provide care for those who have other medical and obstetric needs was considered to be an important issue.

Some midwives who were trained as nurses were concerned that they may have to provide most of the care for women who had particular medical needs, which may eventually lead to there being two types of midwives - those caring mostly for women with normal histories and those who have the expertise to care for high-risk women - which is not in line with current policy initiatives. Issues related to various types of midwifery education have been, and will continue to be the subject of detailed research investigations. Findings from a recent study that followed up some midwives who were not trained nurses indicated that they were 'relatively confident' in meeting the needs of women and babies in both hospital and community settings, except in relation to ill neonates.

However, these findings were based on the perceptions of a relatively small sample(see 201). Further relevant work is being undertaken in relation to the competencies of midwives which is scheduled for completion within the coming year(195). The need for midwives from a variety of backgrounds to work collaboratively with each other, and not to contribute to further fragmentation and/or communication difficulties within the service will be crucial in terms of providing care in line with current policy initiatives(5). Initial and continuing education programmes will have an important role to play in enhancing the potential for greater understanding of the contribution midwives from a range of backgrounds can make to the provision of a woman-centred service. As more information becomes available from research and practice, a clearer picture will emerge regarding the future educational needs of midwives from particular backgrounds, and the potential need for midwives with specific skills to be involved in certain aspects of care provision.

1.2 Practice Base and Grade

A rather complex picture emerged when an overview of key findings from this study regarding practice base and grade were considered. This is of course, understandable as it is likely that there will be an interaction effect between grade and practice base and it will never be possible to separate the two effects completely.

There has been a recent move towards more midwives working in both community and hospital settings in order to provide a less fragmented service, and enhance opportunities for greater continuity of care in line with the recommendations of recent reports(5,6). The findings from this study indicated that just under one in four midwives worked in both community and hospital settings. Wraight et al(3) referred to this group as 'integrated' midwives. The data from this study indicated that there was considerable variation regarding the way 'integrated' midwives worked, suggesting that there is not just one specific group of midwives who work in a totally integrated way in relation to all areas of service provision at this time. (However, the term 'integrated' midwife has been used in this study as a summary term to describe any midwife who worked in both community and hospital settings in their current post). Most 'integrated' midwives worked within a team system.

The majority of midwives reported that they provided a wide range of aspects of care (this has been discussed further in Section 4). However, it is interesting to note that there were some differences reported by midwives in relation to their practice base and grade.

'Integrated' midwives reported that they were involved in providing the widest range of aspects of care overall, and generally, both community and 'integrated' midwives reported that they provided care within a wider framework than hospital based staff. This included being more likely to provide full antenatal care autonomously to low risk women, and to provide total care to low risk women. (This generally meant that midwives considered they took responsibility for providing a wide range of aspects of midwifery care. These issues have been discussed more fully in Section 4 of this chapter). However, community midwives reported less involvement in technical and enhanced role activities than hospital or 'integrated' midwives.

It is important to acknowledge that the data from this study relate to midwives reporting of care provision and it is not possible to determine the *actual extent* of midwives involvement in providing certain aspects of care, and this may differ between particular groups of midwives and between individuals.

It is also important to note that within the group of 'integrated' midwives some effects of grade were reported. In particular, F and G grades reported more experience of providing home births and domino deliveries, but E grades working in both community and hospital settings, indicated that they had more experience of providing such care than their hospital colleagues.

It is interesting to note here that various studies have reported on the effects of grading/skill-mix in the health service, but these have tended to relate to the nursing and health visiting professions(92-3). For example, Carr-Hill et al(1992), in a study of nursing reported that 'grade mix had an effect on the quality of care in so far as the quality of care was better the higher the grade (and skill) of the nurses who provided it, but that the variation in the quality of care between different grades of staff was reduced when higher graded staff worked in combination with lower graded staff'(91).

Midwifery, although in some respects very different from nursing and health visiting, does involve the use of complex knowledge and skills. Grade and skill mix complexities may therefore be of as much relevance as in nursing and health visiting. The findings from this study indicated that those working as 'integrated' midwives were most likely to be working in some kind of team system and therefore to have greater experience of working with staff from a broader range of backgrounds.

It is not possible to determine from this data whether this affected the quality of care provided, but it certainly had an impact on the type of experience midwives obtained. However, many complexities arise, particularly as the work of 'integrated' midwives was organised in such a wide range of ways. It was not possible therefore, for the data from this study to be used to inform an understanding of what may be the optimum way of organising midwifery care. In addition, the ways in which the rotation system has been organised across the country is likely to have had a major impact on the confidence of midwives working in all areas to practise, and these issues have been further discussed below.

Although the majority of E grade midwives did not identify multiple barriers to practise, higher proportions of E grades identified more barriers to practise than those on higher grades. This accords with some of the findings reported in the literature. Such midwives are likely to have substantial contact in their practice with medical colleagues (as the majority are based in hospital), and possibly midwives in a senior position in the hierarchical structure.

The historical legacy of the professionalisation of medicine and the attempts of the medical profession to gain control of a particular knowledge base and systematic body of theory has had an effect on developments within midwifery for many decades(see 68,72). The shift towards the hospitalisation of childbirth also had an effect on the respective roles of midwives and doctors, leading to a high degree of medical input into maternity care.

There have been many developments over recent decades towards an increasingly independent role for midwives but there is still evidence of a lack of confidence amongst certain midwives (particularly those based in hospital and those on lower grades - although of course, not *all* midwives in these groups will experience such difficulties) in relation to undertaking their full role.

Osterman and Kottkamp(1993) define empowerment as '*......a willingness and drive to act professionally and responsibly, grounded in a sense of self-esteem, competence and autonomy...*'(209:186). The empowerment of midwives will be an important component in relation to their facilitation of woman-centred care.

Opportunities for providing care within a broader framework, that facilitate midwives confidence, competence and self-esteem, rather than engender anxiety will be important in promoting the empowerment of those who are currently experiencing difficulties in relation to having the confidence to undertake their full role. The way the rotation system is organised and monitored at local level will be a key component in this process (these issues have been further discussed in Section 1.4).

1.3 Full/Part-time Midwives

There has also been an increasing national trend over recent years towards the employment of more part-time midwives which was reflected in this sample, with almost forty percent of midwives working part-time. Part-time staff were more likely than full-time staff to work in hospital and to be on a lower grade.

Although the majority of part-time staff reported that they provided a wide range of aspects of care, they were less likely than full-timers to report that they were involved in certain activities. In addition, although most part-timers did not identify a lack of confidence in relation to providing many aspects of care, they were more likely than full-timers to indicate a lack of confidence in certain respects.

Part-timers commented fairly frequently on the lack of financial support and time available for them to undertake further study. Such findings accord with much of the literature regarding the part-time employment of women with families and the potential effects on career structure and the nature of work undertaken(see 215). It may well be important therefore, for the continuing educational needs of this group of staff to be addressed more fully. Patterns of part-time working may have an impact on service provision at many different levels. For example, there may be an effect on the continuity of care that is provided. Ways of enhancing opportunities for continuity of care, which may include increased involvement of part-time staff in planning and delivering care within an agreed framework, may help not only to provide a less fragmented service, but also to increase the job satisfaction and levels of confidence amongst midwives(see 94).

1.4 Rotation System

As can be seen from the above discussions the way midwives' work experience is organised is likely to have an effect on the type of care provided. The data from this study indicated that it was common practice for midwives to work within some type of system of rotation.

A number of different systems operated in this respect. There are not any other national data sources available with which to compare these findings as data is not routinely collected in this form. However, Wraight et al, and Stock and Wraight(1993) reported that many midwives were contracted to work for the maternity unit, rather than for one particular area, and therefore rotate to all areas, including the community. They indicated that midwives may follow women through all areas. Most units actually rotated staff through two or more areas, although the vast majority of units also had staff permanently assigned to one area(3,110). The data from this study indicated a broadly similar picture of the situation overall. However, within this framework a large amount of variation still existed both between units and within individual units, regarding both the organisation of the system and the rotation timescale. The picture regarding rotation between community and hospital settings was rather more ordered than that operating in the hospital setting only.

The main concerns raised regarding the rotation system related to midwives feeling that they did not have adequate opportunities to gain the necessary expertise in all areas of practice, leading to considerable anxieties arising in relation to confidence to practise, particularly in areas where regular updating of skills will be important, such as in the delivery suite.

This raised important issues in relation to the concept of an 'advanced' 'specialist' or 'expert' practitioner. This issue has been hotly debated in midwifery, with the profession so far rejecting the role of 'advanced practitioner' on the grounds that midwives should provide women with holistic care (i.e. care that addresses all their needs). The literature indicates a very complex situation exists regarding these issues, with no clear consensus emerging about the best way forward(16,18,61). The data from this study strongly indicated that midwives considered it was extremely difficult for them to be confident and competent to provide the midwifery care required in all practice areas.

What is not so far clear, is the best way of organising midwifery care in relation to staff rotation, and/or the employment of core midwives to provide certain aspects of care. The managers and supervisors interviewed in the case study sites generally supported the concept of a rotation system but did not consider it suitable for all midwives. Some work is currently underway which will provide further information regarding the concept of competence in midwifery practice which may shed light on some of the issues discussed here(195). However, new systems will continue to need careful evaluation in relation to the most appropriate organisation of rotation systems, in terms of both structure and timescale. Such findings will be important in providing much needed information about the need (or otherwise) for specialist input and the level of expertise that would be most appropriate in a range of practice settings and within the systems of care that are currently operational (e.g. team midwifery, caseload management, group practice care).

The need to provide an optimum service in relation to meeting women's needs is evident, and providing a service that enhances continuity of care is likely to promote such a process(29,64). It is also important to note there is some indication that that midwives' job satisfaction may well be positively associated with having the opportunity to use a range of skills, exercising their independence and autonomy, having the support of their peers and providing care that meets individual need(e.g. 169-170,180). However, enhancing the potential for addressing the needs of both mothers and midwives is not necessarily at odds with some aspects of care being provided by a midwife with particular expertise. Good communication patterns between midwives, and between midwives and women, and the provision of care underpinned by a similar philosophy, may well enhance the quality of care provided, and lead to a greater sense of satisfaction for midwives.

Current developments aimed at moving the midwifery profession to the point where all staff are on the minimum remuneration equivalent to F or G Grade are likely to ease current problems related to the grading structure which have been proliferatively covered in the midwifery press, particularly since the publication of Changing Childbirth. However, the findings from this study indicated that both practice base and grade have reportedly led to some differential effects arising in relation to midwives' experiences and confidence levels, which may affect the quality of care provided. Attention to remuneration issues, although of the utmost importance, may be only one aspect of the solution to a situation that has developed over many years.

It will be important for continuing education programmes to facilitate greater confidence and competence in midwives to provide optimum care to women - particularly those midwives who may have worked in a specific practice setting for many years without having undertaken further education. Local support will be important in this respect to assist in the meeting of individual need, and the involvement of midwife supervisors in this work will be of considerable importance.

SECTION 2 PROVISION OF MATERNITY CARE

2.1 Home Births

A wide range of methods of organising and providing midwifery care were evident countrywide. The picture that emerged was broadly similar to other relevant data, where this exists(3). Although the majority of units offered domino care and home births, only a tiny percentage of births occurred under these systems (for the year 1993), and there was not any indication that the number of home births was increasing(see 6).

There was considerable discussion during the case study interviews about home births, and in the light of the importance of these issues in relation to current policy developments, the main issues have been discussed in some detail. The main barrier identified by midwives, supervisors, consultants and registrars to women having home births was the attitude of GP's.

There was general support from midwives for women's right to choose a home birth. Safety issues were considered paramount but for low-risk women, home birth was not considered a high risk event, a view which is generally supported by the available evidence(74,190,192). Some midwives considered it to be a shame that GP's prevented women from taking up this option but did not consider they could really do a great deal about it. However, other midwives did whatever was necessary to support the woman's decision, including helping her to look for another GP if that was what the woman wanted.

It is also interesting to note here that the biggest concern raised by **mothers in this study** regarding lack of opportunity to discuss their choices and wishes for their pregnancy and the birth related to place of birth issues. Approximately one in five mothers commented. Comments focused mainly around not being asked about the type of care they would like, particularly with regard to the place of birth. The midwives were seen as being just as likely not to facilitate the discussion about place of birth as doctors. None of the midwives gave the impression of wanting to prevent women from having a home birth but some midwives obviously required further confidence in relation to finding ways of effectively dealing with potential barriers to practise, at all levels within the service.

Such issues are particularly topical in relation to current debate about the role of the GP in the future maternity service, especially in relation to intrapartum care(70,80). Of particular importance here is a recent statement jointly issued by the RCM and RCGP that supports women's right to have a home birth, and GP's who do not wish to provide such care are advised to refer the woman to a local midwife or supervisor of midwives. The statement clearly indicates that the midwife is responsible for the care she provides(81).

Obviously, midwives will not be expected to just accept the refusal of the GP as a justification for not working towards facilitating women's choice in the future. The position regarding midwives' responsibilities has not actually changed in any way over recent years - they have always had the responsibility to provide care to women wanting a home birth. However, recent policy and practice developments have brought some previously unresolved issues to the fore, which the profession will need to address.

A further point that it may be important to address for continuing education purposes relates to the lack of opportunities there are for many midwives inexperienced in home births to gain the necessary expertise. As so few home births occur, widespread educational opportunities are not likely to be available across the country. If more home births occur overtime, opportunities may increase.

However, it is not currently possible to determine what the true demand will be. Even if choice is available it is likely that only a small percentage of women may wish to have a home birth(186,187). Education programmes in midwifery will need to address what may well become a rather complex situation in relation to the future teaching of midwives to provide optimum choice for women. Of course, some argue that any midwife should be able to deliver a baby anywhere, including in the home, but the data from this study indicated a certain lack of confidence by some midwives in this regard.

On the positive side, locally organised systems of support for midwives providing home births were evident in many places. For example, two midwives might attend a home delivery in all cases. Such systems will obviously be important in enhancing education and quality issues but changing patterns of care may have resourcing implications, which will need to be closely monitored.

Moving on from the specific issue of home birth into more general issues concerning care provision, it was evident that key concepts underpinned service delivery in order to facilitate the provision of an optimum service to women. Issues that were widely discussed in this context have been discussed below.

2.2 Continuity of Care

Team midwifery was the most commonly identified means of ensuring continuity of care by midwives and supervisors, with caseload management generally being discussed under the 'team' heading. The named midwife was the second most commonly mentioned way of ensuring continuity. Overall, the picture emerged of continuity being least in evidence in relation to intrapartum care but continuity was often reported to be good throughout both the antenatal and postnatal periods.

Wraight et al reported that a wide range of team systems were in operation(3). They also found that a significant number of team midwifery schemes had been discontinued due to a variety of problems, although a substantial number of units indicated their intention to set up a team system in the future. At the time of Wraight et al's study, 40% of units operated some kind of team midwifery system. The data from this study indicate that 53% of the units operated such a system. Thirty one percent of supervisors indicated that they were planning to implement a team system in the future. The data from the two studies are not directly comparable as Wraight et al carried out their work in England and Wales, and this study focused solely on England. However, it appears likely that the percentage of units operating a team system has increased in recent years on the basis of data from the two studies.

Various types of team systems were still in operation at the time data were collected for this study but the overall picture emerged of community based teams functioning quite well. They were reported to be fairly small and to provide continuity of care to women in the antenatal and postnatal periods. The named midwife system appeared to operate well within this framework in many cases, with women having a named midwife who was responsible for planning and delivering a substantial part of the care with support from other team members. However, there was not much evidence of the teams providing a substantial amount of intrapartum care, although there were some examples where this did seem to be happening effectively and other units were making plans in this respect.

The picture that emerged of hospital care was generally less organised. In some places large teams existed but did not provide a high degree of continuity of carer, and in many cases there was no indication of a clear philosophy of care in operation to enhance continuity of caring either (where continuity of *carer* refers to care being provided by the same person, and continuity of *care/caring*, denotes care that is underpinned by shared philosophies so that all those in contact with women provide the same care(64)).

Furthermore, the named midwife system had also been implemented in some places, sometimes operating within these large teams, and there was no indication that this improved continuity of carer or caring in any way either. There has been much debate recently about the implementation of the named midwife and named nurse, which raise important issues about the likely effects of implementing such concepts(75,78).

Care is not necessarily going to be improved by just ensuring that each woman has a named midwife. It will be important for local assessments to be made of how the named midwife system is operating and what the benefits of such a process are likely to be on the quality of care provided, as well as the effects on the midwives who are providing the care. The meeting of indicators is not necessarily synonymous with providing the type of care the indicators have been set to promote.

The information provided by professionals was supported by the consumer data obtained for this study which indicated that women saw a small number of midwives antenatally and postnatally who got to know them well, but generally someone else provided intrapartum care. However, one of the main concerns reported related to midwives giving inconsistent advice, especially in relation to infant feeding, indicating the importance of continuity of caring. These findings regarding the importance of consistent information and advice is in line with other findings reported in the literature(e.g. 23)

Care plans and/or birth plans were one of the most frequently mentioned ways of facilitating women's choices but this was generally not specifically linked to ensuring continuity. No one spontaneously mentioned the concept of the lead professional as a potential means of ensuring continuity, despite the fact that large numbers of midwives and supervisors considered the midwife should be the lead professional for low risk women.

2.3 Responsibility For Providing Maternity Care

2.3.1 The lead professional

The issues related to the lead professional bring the discussion on to the implementation of Changing Childbirth. Data from both this study and a survey undertaken by the ENB(95), indicated that by the autumn of 1994 substantial progress had been made countrywide in relation to implementing many of the Changing Childbirth indicators of success. It is particularly interesting to note here that there was considerable variation regarding the extent to which midwives, supervisors and doctors working in the same unit reported that the indicators of success had been implemented.

This indicated potentially important issues in relation to the knowledge of staff about the policies that are being implemented - and consequently the potential impact of implementation on practice - and indicate that communication strategies within units may need to be addressed in order to maximise the potential for the effective implementation of initiatives at local level.

The questions related to the lead professional raised some interesting issues. The 'lead professional' was defined as in Changing Childbirth: *"the professional who will give a substantial part of the care personally* ***and*** *who is responsible for ensuring that the woman has access to care from other professionals, as appropriate".* As well as asking in the questionnaire who should undertake the lead professional role for low risk women, respondents were also asked who should carry **overall responsibility** for the care of low risk women. This second question was asked to find out how professionals viewed the role of the lead professional in relation to carrying overall responsibility for care.

The majority of midwives, supervisors and hospital doctors considered that the midwife should be the lead professional antenatally, during labour and delivery and postnatally. However, GP's were much less likely to consider the midwife should undertake this role. They were most likely to consider the role should be undertaken by the GP and midwife together, or by the GP, antenatally and postnatally, and by the midwife and hospital doctor during the intrapartum period. Of course, the idea that the lead professional role should be shared runs contrary to the principle outlined in Changing Childbirth that the woman should have one professional fulfilling this role to enhance continuity and integration within the service.

However, the picture changed somewhat when the question regarding overall responsibility was posed. The majority of midwives and supervisors maintained that midwives should fulfil this function. However, hospital doctors and GP's were less likely to consider midwives **should carry overall responsibility** than considered midwives should be the **lead professional.**

Several reasons for these findings emerged. One major concern put forward by some GP's and hospital doctors related to the view that having a 'lead professional' conflicted with the 'team approach' to care - although Changing Childbirth does not indicate in any way that professionals should not work as a team. In fact, the importance of good communication and less fragmentation of care is stressed. There was a feeling that the term inferred a hierarchical relationship which may damage, rather than enhance collaborative working. Such thinking is in line with some of the views outlined in the literature, with some doctors proposing that the term 'link' professional would be preferable(85). Interestingly, none of the doctors indicated that being the lead professional themselves or carrying overall responsibility was likely to undermine teamwork in any way. It only seemed to pose a problem when it was proposed that midwives should fulfil such a role.

A further point made by doctors related to the problems midwives may have detecting 'deviations from the norm' as early as possible, for example, in relation to complications in early pregnancy or medical conditions such as heart disease. Midwives and supervisors did not identify a problem in this respect as midwives education was considered to equip them with the skills to detect abnormality effectively. This issue may become even more contentious in the future in the light of earlier discussions about the potential ability of midwives who are not trained as nurses to detect and care for women in a high risk category.

A further issue that was raised particularly by some GP's in relation to midwives responsibility for care provision, related to the perception that midwives often do not accept responsibility for their actions and turn to doctors when difficult situations arise.

There was evidence of some confusion about the role of midwives in relation to providing care in low and high risk situations. For example, several comments were made by GP's indicating that if midwives really want to be autonomous and carry responsibility for care, they should not expect to hand over responsibility to doctors when 'things go wrong', such as a woman having a haemorrhage or requiring care following a miscarriage. Although midwives may well be involved in providing care in such circumstances, the Midwives Rules are clear - where a deviation from the norm occurs, the midwife should call a registered medical practitioner to her assistance(47). Although there may be guidelines at local level that provide definitions of low and high risk situations, confusion very clearly exists as to how such guidelines might be most effectively used to inform practice.

The issues that have been discussed here have been raised many times in the literature, with much debate about the extent to which pregnancy and childbirth should be viewed as a normal, healthy life event, or whether the potential for complications justifies medical involvement in all cases(85,111-112). Midwives education aims to equip them to provide and arrange all maternity care for women with uncomplicated pregnancies, and legally they are able to practise independently. However, there has not been much opportunity to evaluate the extent to which midwives actually fulfil such a role, as to date there has been some degree of medical involvement in much of the maternity care provided within the NHS.

However, despite the comments outlined above, doctors often reported that they had great respect for midwives skills and professionalism, and it is possible that those who chose to comment most vociferously on these issues were those who considered there were problems to discuss. However, the issues have been discussed at length here as they are important in furthering an understanding of the issues that may affect the scope of midwives practice. The situation seemed therefore to be rather complex, particularly in relation to the autonomy and control of the respective professions regarding service provision.

2.3.2 Duplication of work by health professionals

The duplication of work by professionals providing maternity care was identified in Changing Childbirth as a problem requiring concerted action in the interests of all concerned. Interestingly, the findings from this study indicated that supervisors were most likely to consider that there was some degree of unnecessary overlap between midwives and doctors. Only approximately half the midwives and consultants considered this to be the case, with only one in five GP's considering there were areas of unnecessary overlap.

The GP's who commented tended to be of the opinion that a certain amount of overlap in care provision was necessary in the interests of 'patient safety' and continuity of care. The main area of overlap identified by midwives and supervisors related to the unnecessary involvement of doctors with low risk women, particularly in antenatal clinics and the delivery suite, where double checking was reported to be a frequent occurrence.

The comments made by the GP's about safety were made more in relation to the midwives' work being checked by doctors rather than the other way round. Again raising the point about the need for medical involvement in all care. The issue about GP involvement in relation to ensuring continuity of care is a complex one, but as has been discussed above, continuity of care can be enhanced by good care planning and inter-professional communication which may help to alleviate unnecessary duplication of effort.

Although there was an obvious tendency towards duplicating work by certain doctors, midwives may have also contributed to this process in many ways, with doctors, supervisors and midwives in this study all identifying some difficulties in relation to midwives accepting responsibility for providing care that is clearly within the remit of the midwife. This state of affairs has been discussed at length in the midwifery literature, with the importance of midwives being more willing to take responsibility for their actions being stressed(125).

2.3.3 Autonomy of midwives

Many reasons may have contributed to the situation outlined above arising. For example, as has already been discussed, the historical legacy left by the professionalisation of medicine and its attempt to gain control of a particular knowledge base, has ramifications for the way midwives have viewed their role(68,72).

Nowhere in the Midwife's Code of Practice does it state that midwives should be autonomous practitioners but the terms 'autonomous', 'independent' and 'accountable' often seem to be used synonomously in the midwifery literature with locally determined policies and procedures frequently being seen by midwives as imposing unjustified restrictions on their practice, which was supported by our data, particularly in relation to E grade midwives based in hospital.

An interesting point is made in this context by Fraser(1995) who hypothesises that midwives must not be autonomous in the political sense but should be appropriately autonomous in a client-centred sense. *'Control must be given to, not taken from, the mother and therefore midwives need to be clear what autonomy they are aiming for. I would suggest that autonomy for a midwife implies a responsibility to know when she is free to take a decision...'*(210:175).

Leading on from this point, the data from this study indicate that as midwives become involved in a wider range of practice situations, it may be important for them to carefully consider issues related to autonomy and independence in whatever practice situation they are required to provide care.

For example, working effectively within a team which may have professionals from a broad range of backgrounds within it has been identified as an important component in relation to providing a quality service(160). There may be times when it will be appropriate for midwives to work within this kind of framework, whereas on other occasions they may be providing a more substantial part of the care outside the team framework.

It will be important that midwives' autonomy, and their capacity to facilitate women's choices is not undermined in any situation in which they are practising. Midwives will need to have a range of skills to assist them in negotiating their practice with women and other professionals and managers, in order that they may be able to remain accountable for the decisions they make, and those decisions that may be made within a team framework, without compromising their own professional code of practice.

An interesting picture emerged in relation to independent midwives. They generally reported providing care within a wider framework than NHS midwives, and provided a higher degree of continuity of carer throughout the maternity episode, including the intrapartum period, and they tended to identify less barriers to effective practise than NHS midwives. However, they indicated that they considered local policy and procedures a greater barrier to practise than NHS midwives. This related to the need for them to negotiate access to NHS premises and facilities at times.

Obviously, there are many differences between the systems that NHS and independent midwives work in, which are too complex be summarised here. However, potentially important points are raised by such results, in relation to the effects of organisational structures and systems of care delivery on service provision. This may be particularly important as independent midwives are contracted to provide services for local health authorities/Trusts and is another area where further research may provide useful results to inform practice. Some work is currently in progress in this area(116), but as practice develops it will be important for rigorous research and evaluation work to continue.

2.3.4 Midwifery supervision

Local support will have an important role to play in facilitating optimum midwifery practice. Supervision is likely to be an important component of the local support and quality monitoring process. These issues were widely discussed in the case studies, particularly by midwives.

The concept of supervision was viewed as having the potential for enhancing practice. However, the need to ensure that midwives felt supported by the system, and respected the midwifery skill and expertise of the supervisor was stressed. This may be particularly important in the light of the finding that the majority of supervisors in this sample were not regularly involved in providing care. Also, the majority of co-ordinating supervisors were also the Head of Midwifery or the equivalent for the service, with an important management function. This was seen by some midwives as contributing to a 'credibility gap' emerging in relation to the ability of the supervisor to effectively undertake her role. However, it is important to note that the sample of co-ordinating supervisors used for this study, may have been less likely than other supervisors to be regularly involved in clinical practice as a result of other important aspects of their role and responsibilities. There has been widespread debate recently in the midwifery literature about the potential role of the supervisor in facilitating practice, with various recommendations being made for future practice(e.g. 167) The findings from this study provide support for developments within the supervision process and highlight the need for evaluation of various models of supervision in order to inform future practice.

Providing the best care possible will involve many complex processes and the relevant issues have been discussed in the next section.

SECTION 3 QUALITY ISSUES

3.1 Quality of Care

The issue of quality of care was discussed in various ways throughout the study. The first interesting point relates to the fact that midwives and supervisors were much more likely than doctors to consider that the implementation of the Changing Childbirth indicators of success would improve the quality of the maternity service.

All the professional groups studied raised concerns to some extent about the potential resourcing issues. It was considered that implementation, particularly with regard to every woman having a named midwife/lead professional, and knowing the person who cares for her in delivery would make more demands on the midwifery resource. It is difficult to assess the resourcing issues related to the implementation of Changing Childbirth as comparable data sets are never likely to be available as so many changes have been made recently to the way midwifery care is organised and delivered that comparisons with previous systems would not be appropriate. However, the fact that a substantial number of those involved in planning and providing the care raised concerns about the resourcing implications is an important finding and such issues will need to be carefully monitored.

The other main concern raised particularly by doctors related to whether the indicators of success would really improve the quality of the service. For example, there was not an obvious link to many between having a named midwife and/or lead professional, and better care. They were often unable to see how research had been used to inform the report. There was very little discussion about how implementing the recommendations in the report might lead to better communication within the service, or choice, control, or continuity of care for women.

During the case study interviews the issues of quality of care and what makes a 'good' midwife were discussed. Again, Changing Childbirth was not often mentioned as being likely to have an impact on such issues.

A substantial number of maternity units had a strategic plan and/or targets and goals outlined for service provision, as well as a system in place to monitor consumer satisfaction. However, there was not much evidence of structured quality monitoring procedures being used by the majority of staff to inform care planning. In some cases, clinical audits, patient satisfaction surveys and the collection of morbidity and mortality statistics were mentioned rather more as a list than as having any apparent significance in relation to the care provided.

Several similar issues emerged from all the groups studied and from the fairly small sample of mothers interviewed for this study, in relation to 'good midwifery' care. Good communication skills (including listening) and being approachable and caring were generally considered important. These findings are consistent with much of the literature that has been reported on what women want in relation to their maternity care(34-37).

There was very little spontaneous discussion regarding the types of knowledge that may be used to underpin quality care, and ways of drawing on clinical experience and research-based information to inform knowledge-led or evidence based practice, in line with current developments, were not discussed(124,96). There was also no real discussion about 'midwifery knowledge' or the potential that midwifery models might make in relation to informing woman-centred care, despite there being a lot of recent literature debating such issues(e.g. 87,156).

However, despite the apparent lack of formal frameworks to inform care planning it is interesting to note that the midwives particularly, provided many examples that indicated a strong sense of being aware of the need to provide woman-centred care. In many cases clear efforts were being made to ensure that everything the woman required was provided as far as possible within resourcing constraints. Furthermore, both midwives and supervisors identified the importance of midwives having a broad range of skills and attributes, including good research and communication skills, and being a good team worker and autonomous, in order to provide an optimum service to women.

3.2 Facilitation of Woman-Centred Care

Several examples that have been outlined in Chapter 6 illustrate the efforts midwives had made to find out what the woman wanted in respect of her care and to provide that, such as continuous monitoring during labour, even if the midwife herself did not necessarily think that was the best way to provide care. The data obtained for the consumer aspect of this study indicated that the majority of mothers considered that they had sufficient opportunity to discuss their choices and wishes for pregnancy and the birth, with the midwife being the professional they were most likely to have such discussions with.

Furthermore, a range of strategies were used by midwives to facilitate women's choices for their pregnancy and the birth including the use of birth plans. One interesting point that may have implications for the provision of a woman-centred service relates to the way professionals view their role in relation to the woman. There is an extensive literature focusing on the way power dimensions may influence communication between professionals and service users, which may limit the potential for a truly woman-centred service(e.g. 210,135).

There was some evidence of this happening in this study. For instance, when providing examples of ways in which they facilitated women's choices some midwives indicated that they *'allowed'* women to choose certain options - such as the person they wanted to have with them during labour and delivery. The use of the word *'allow'* indicates the existence of a power relationship, with the midwife being ultimately in control of what the woman may or may not choose to do.

However, on the whole, there were many positive examples of midwives working towards a more woman-centred service, although inevitably there was a considerable amount of individual variation in the extent to which this appeared to be occurring. Data obtained from the mothers for this study supported this picture of variation between midwives regarding the extent to which they provided care appropriate to the needs of the individual. This clearly indicated the importance of individually tailored education and development programmes, which midwives, supervisors and educators together may be best placed to negotiate.

3.3 Effects on the Midwife of Providing Optimum Care

Midwives were clearly under pressure, both from themselves and from management and service users to provide an optimum service to all those accessing the service. Page et al(1994) discussed the potential effect on midwives of providing one-to-one midwifery care for a group of women. They concluded that *"These midwives tend to be altruistic individuals, very committed to good care and the profession. One problem of such a service is that the midwives expect a great deal, sometimes too much, of themselves, and support is needed if they are prone to overperfection and exhaustion"*(63,446).

The data from this study indicated that this state of affairs may be arising in many cases across England, even though different systems of care may be being implemented to provide an optimum service to local populations. It will be important that midwives, managers and service users remain realistic about the care that midwives can provide within a professional framework without having to rely heavily on 'altruistic' individuals to provide an optimum service. Perhaps it will be useful to look towards the 'good enough' midwife, rather like the 'good enough mother', as opposed to the 'perfect' midwife. Interestingly, doctors were more likely than midwives to discuss the possibility that it may not always be possible to meet everyone's expectations, but that does not mean that the quality of the service provided has to be compromised. Further work related to evaluating quality issues in a more structured way may help to clarify some of these issues for future developments within the service, and possibly to reduce the very real pressures on midwives trying to meet enormous, and perhaps at times, unrealistic demands.

3.4 Midwifery Representation in the Management Structure

Another point of considerable importance concerns the way in which midwives are represented in the organisation in relation to decision making processes. The majority of Heads of Midwifery or equivalent were accountable to either the Chief Nurse (or equivalent title) or the Clinical Director of Obstetrics and Gynaecology (a consultant), or they were jointly accountable to a clinical director and a general manager.

They were rarely members of the hospital/trust board which clearly affected their role in relation to making key decisions about maternity service provision. This issue was discussed by midwifery managers during the case study interviews, with the importance of the Head of Midwifery being represented at Board level being stressed. Those who are not midwives were not generally considered to have the understanding necessary to represent midwifery issues appropriately, and not having a midwife represented at the same level as nurses and medical staff led to a feeling of the profession being disempowered and not having professional credibility within the service.

These issues have been much debated in the midwifery literature since the Griffiths Report(129) when midwifery lost a lot of its managerial authority. Strong organisational representation is clearly important when decision making is taking place, and the strong view from the midwifery profession that it is not being adequately represented or heard at the right level will undoubtedly affect the way midwives interact with colleagues and view their professional role within the service. Such issues may well have knock-on effects on practice. It will be important therefore, for the midwives' role in the decision making processes to be carefully considered, particularly at a time when the profession is being urged to make such fundamental changes to its structure and practice.

This section moves on from the broad frameworks within which care is provided to consider in more detail the aspects of care provided by midwives.

The majority of midwives reported that they provided most of the activities of a midwife in their current position. Obviously, as has been discussed above there were some differences in relation to the aspects of care provided by practice base and grade, and the extent of midwives involvement in each of the activities may well vary. Within the broad remit of this study it was not possible to provide a detailed picture of the extent of midwives involvement in each activity, but the data obtained served to provide an overall picture of the current scope of midwives practice countrywide, and allowed for an understanding to be built up of the areas where midwives reported that they lacked confidence and/or the skills to provide aspects of care, and required further education.

Supervisors, midwives and hospital doctors generally reported a similar picture in respect of the care midwives provided. General Practitioners were less likely than the other groups to report that midwives provided medical aspects of care in the absence of a doctor, which may reflect the fact that they have less contact with midwives when such care is likely to be required.

There are not any other data available that are directly comparable with the findings from this study. However, a large national study of the role and responsibilities of midwives reported by Robinson et al 1983, indicated that *"a substantial proportion of midwives practised in situations in which they were not required to exercise fully the degree of clinical responsibility for which the midwife is trained and this was particularly the case with regard to the provision of antenatal care"*(7:328). Medical staff were significantly less likely than midwives to indicate that midwives were the ones making decisions concerning normal antenatal and intrapartum care. Those midwives who did fully exercise their clinical responsibility differed significantly by the type of practice situation.

There are some similarities between the study undertaken by Robinson et al and the current study. In particular, midwives working in hospital were less likely to report that they provided full antenatal care autonomously to low risk women or to provide total care to low risk women - an obvious practice base effect.

General practitioners were more likely than midwives (hospital, 'integrated' or community based) or hospital doctors to report that midwives provided full antenatal care autonomously to low risk women. However, further exploration of the data indicated that a more complex situation may arise. Responses to other questions indicated that doctors, including GP's were generally less likely than midwives to consider midwives carried overall responsibility for care provision.

Furthermore, there was very little indication of NHS midwives providing antenatal care without the involvement of doctors at several stages. This may indicate that different definitions of the terms are being used. General practitioners may have indicated midwives were undertaking this role even though they were still heavily involved in care provision themselves.

4.1 Provision of Autonomous/Total Care by Midwives

Some midwives considered they were providing full antenatal care *autonomously* when they provided all the *midwifery* care required, even though a doctor might still be involved in providing other aspects of maternity care (even if the midwife's and doctor's role overlapped to some extent). However, other midwives only considered they provided care *autonomously* if a doctor was not involved in care provision at all.

This can be seen to relate to the earlier discussions about autonomy, and when a midwife might consider she is practising autonomously. Views clearly vary. There may be times when it is most appropriate for midwives to negotiate 'midwife only' care but they cannot be held accountable for doctors insisting on continuing their involvement in care. It may be more important for midwives to define autonomy in relation to their own practise and not in relation to being the only one involved in care provision. This seems to be more in line with current policy developments, such as the recommendations outlined in Changing Childbirth(5)

Community and 'integrated' midwives were more likely than hospital midwives to report that they provided total care to low risk women. On the whole, this seemed to mean that they provided all the midwifery care required by women antenatally, during labour and delivery and postnatally. However, this did not necessarily mean all care was provided for the *same* woman. For example, community midwives sometimes provided all the antenatal, intrapartum and postnatal care required by a small number of women having a home birth or domino delivery. However, they did not provide intrapartum care to the majority of women they cared for. The points made here indicate that terms and concepts may be being used in variety of ways within the maternity service. This supports the need already identified for more consistency in the use of terminology in relation to furthering an understanding of the care that is provided countrywide. This will be particularly important if rigorous evaluations are to be undertaken to inform care provision(113).

4.2 Confidence of Midwives to Provide Care

As has been outlined above a very wide range of aspects of care can be provided within the framework of the activities of a midwife. The aspects of care that midwives were most likely to lack confidence to provide related to those that broadly sit within the remit of the activities of the midwife, but have generally been considered as 'enhanced' aspects of the role, although this has never been formally defined by the statutory bodies, nor the professional literature. It will obviously be important that continuing education programmes are available at local level to meet individually determined need in relation to clinical skills, as needs will change over time as practice developments occur.

It is interesting that many of the issues identified in this study by midwives as continuing educational needs were also reported as priorities for further research in midwifery by Sleep et al following a national survey of midwives(120) (e.g. fetal monitoring in labour, water births, perineal suturing). This may indicate the importance midwives attach to obtaining reliable information on which to base their practice.

A further area that needs to be addressed both in terms of education and practice is counselling. Midwives are expected to be involved in 'health' counselling and education(9). The data from this study indicated that this was occurring widely at many different levels within the service. Examples ranged from the provision of information and advice about lifestyle at one end of the spectrum, through to giving social support, to working with women suffering the effects of bereavement, at the other end of the spectrum. Midwives were often unclear about the boundaries of their role in relation to counselling, which may result in problems arising both for the women they are working with, and for midwives themselves(152-153).

It has been suggested that all midwives will need to have *counselling skills*, allowing for caring, listening and reflecting to occur(164), but that more formal *counselling* may require a clear bounded structure, adequate training, supervision and support for the counsellor, and a contract between counsellor and client(164,152).

It will be important that education programmes address such issues in the future, and that midwives and those they are working with (other professionals and service users) understand the boundaries of the midwife's role in this respect, and when and how other expertise needs to be made available. Obviously, as in many areas of midwifery practice grey areas will occur, and midwives may well be the only ones available to a mother at a crucial time, but clearer education and practice strategies regarding counselling related issues can only help to minimise the potential problems for all concerned.

4.3 Social and Emotional Aspects Of Care

The effect of social support during pregnancy has been widely discussed in the literature. A wide range of examples were provided by midwives indicating that they provided social support within a very broad framework rather in keeping with the definition provided by Oakley of the *'provision of a non-judgmental listening ear, discussing with women their pregnancy needs, giving information when asked to, and carrying out referrals when appropriate to other health and welfare workers and voluntary and statutory agencies'*(168:31-32).

It was not possible to determine from the examples given the extent to which a 'non-judgmental listening ear' was provided but midwives reported widespread involvement in discussing needs with women, providing information when asked to, and referring on, when the need was identified.

Other data from this study indicated that the extent to which a non-judgmental stance was taken by midwives was subject to a certain amount of individual variation. This was particularly notable in relation to meeting the needs of women from a range of social and cultural backgrounds, where some evidence of stereotyping was apparent, which accords with other findings reported in the literature(e.g. 143). However, there were also many obvious examples throughout the study of midwives, supervisors, doctors and mothers reporting the provision of sensitive and responsive caring by midwives.

4.4 Supervisors' and Doctors' Perceptions of Midwives' Competence to Practise

Interestingly, supervisors and doctors identified problems in relation to midwives' competence in the areas where midwives themselves indicated a lack of confidence (e.g. enhanced role skills). However, generally the picture was not one that indicated widespread concerns in relation to the competence of midwives to practise various aspects of their role, but again, the significance of individual variation in relation to both competence and motivation to provide a woman-centred service was stressed. Some doctors raised the issue of midwives' capacity to take responsibility for their practice, and these points have been discussed in detail above.

As has been touched on earlier, the issues of 'competence' and 'competencies' in midwifery are somewhat complex(200), and it was beyond the remit of this study to pay detailed attention to such issues. However, in view of the close working relationship midwives have with supervisors and medical colleagues it was considered that a useful purpose would be served by some questions focusing on the extent to which these groups perceived midwives to be competent in relation to care provision - i.e., within a peer review framework. It is important to note that competence was not defined by the researchers, but respondents were left to make their own professional judgement in this respect. When considering these findings it will also be important to take into account that responses were based on individual perceptions of competence and there were no other data collected to validate these findings. However, the data obtained added a wider perspective to the other study findings.

SECTION 5 CONTINUING EDUCATION NEEDS OF MIDWIVES

As can be seen from the discussions so far, continuing education and training needs varied widely from individual to individual, although there were some indications of particular needs being apparent in relation to grade, practice-base and full/part-time working.

However, another important component of the findings relates to the direct identification of midwives continuing education and training need by themselves and their supervisors. Key issues identified in this respect included, clinical skills, research, communication and counselling skills, and general 'professional' issues. Some needs will have to be identified and addressed at local level, such as learning and practising clinical skills. Other specialist skills, such as those related to counselling will also be best addressed through programmes that have been designed for that particular purpose. It is interesting to note here that the move of midwifery education into higher education institutions was not directly discussed often by respondents. Midwives appeared to accept the situation as the 'status quo'. However, indirectly relevant issues were addressed, in particular the perceived need for midwives to gain academic accreditation.

5.1 Development of the Educational Package

However, it has been possible to address several of the issues identified for the continuing education of midwives through the educational package that has been developed on the basis of this research study. In particular, the package has been designed to allow for individual need to be addressed through the use of an open learning approach.

The package focuses on developing the potential for a woman-centred service through using two workbooks. The first book concentrates on Relationships in Practice and the second book addresses issues related to the Context of Care. Communication, power, knowledge bases, and the development of philosophies of care are addressed through the first book. The second book explores ways in which personal practice and the maternity service can be adapted and improved to meet the needs of service users. This includes a section on the management of change within a constantly developing service. Emphasis has been placed on the development of confidence to practise and the empowerment of midwives in relation to providing a woman-centred service.

As education programmes move towards implementing the ENB Guidelines for Midwifery Programmes of Education: Lifelong Learners(71), the continuing educational needs of midwives may well change. However, the package that has been developed on the basis of this research study has been designed in relation to current policy, practice and education developments, and the learning handbook that accompanies the package will allow for the assessment of individual need before work begins. By adopting this approach, the intention has been to enhance the potential for optimum use of the package by midwives for many years to come.

5.2 The Role of Professional and Statutory Bodies

There was clearly considerable commitment to developing continuing education policy and practice from the professional and statutory bodies for midwifery. Procedures were in place to ensure that education meets the quality and standards that have been determined for implementation at national level. Several educational developments have recently been established by the ENB in relation to the continuing education of midwives, such as the Changing Childbirth Midwifery Educational Resource Pack(149). The package that has been developed on the basis of the current study builds on such developments in order to facilitate the move towards a woman-centred service.

During the interviews that were undertaken with representatives of national organisations it was apparent that there was a strong commitment to developing continuing education initiatives for all the professionals involved in maternity service provision, and collaborative work is underway between the relevant professional organisations. However, all the representatives interviewed considered that stronger cross-organisational links were necessary at decision making levels, particularly if the further development of multidisciplinary education is to be seriously contemplated. All those interviewed supported the principle of multidisciplinary education, but identified the need for further collaborative work to be undertaken before it becomes a serious prospect countrywide.

SECTION 6 EVALUATION OF MIDWIFERY CARE

6.1 Provision of Maternity Care

Finally, in the light of the enormous amount of change that is occurring within the NHS generally, and specifically in relation to the maternity service, it will be important for as much information as possible to be obtained regarding the impact of such changes on service provision. The situation is extremely complex, and there is the potential for the effects of changes to have an impact on the service at many different levels. For example, effects may occur in relation to:

(i) service-user satisfaction,

(ii) the processes and/or outcomes of care,

(iii) potential effects on those providing the service.

To complicate matters further there may be interactive effects between various issues which it will be difficult to untangle. Furthermore, as so many changes are occurring at many different levels it will often be difficult to compare 'original' and 'new' systems as reliable data sets will not be available.

6.2 Changing Childbirth

A particular problem arose in that different interpretations of the indicators of success were being used across the country, with a very wide range of definitions being applied to a woman 'knowing' the person who cares for her during labour and delivery, in particular. At the time that data were being collected for this study there was little evidence of well thought out strategies being used at local level to evaluate the effects of changes in a way that would really inform service planning and provision.

Guidance is available from the office of the Changing Childbirth implementation team to assist with local evaluative work which may help with the planning and implementation of local developments. However, as a key principle underpinning Changing Childbirth is tailoring services to the needs of local populations, there will not be reliable and valid sources of information available that can be used to assess a national picture of maternity service provision. It will therefore be important that data collected at local level is as rigorous as possible in order that an understanding may be built up of the extent to which services are addressing need.

6.3 Deployment of the Midwifery Workforce

There is extensive coverage in the literature concerning resourcing issues in the maternity service, with a lot of the emphasis placed on the organisation of midwifery care, particularly in relation to the terms and conditions of employment for midwives. The data from this study indicated that such issues were of considerable importance to midwives and managers alike, with a strong commitment evident from many to provide the best possible service.

However, plans were often being made to reorganise midwifery provision on the basis of little reliable information, particularly in relation to the mix of grades and the number of midwives within a team. Particular concerns emerged concerning the potential effects of ways of organising care provision on both the personal and professional development of midwives.

The way the rotation system was organised was identified as a particular priority in this respect, especially in relation to the most appropriate timescale for rotation to specific practice areas, and the type of experience and support midwives need to provide them with the confidence and skills necessary to provide an optimum service. Leading on from these issues, the extent to which all midwives should provide holistic care, and the potential need for those with specialist skills to provide specific aspects of care, was identified as an area where further investigation is necessary.

Difficulties in matching scarce midwifery resources to the growing expectations of women using the maternity service caused obvious divisions between those planning and those delivering care. Little data is available to assist decision making in this context. There is a particular paucity of data regarding the costs and effectiveness of different types of midwifery provision, and the potential deployment of the midwifery workforce in this context. Various studies are currently focusing on some relevant issues(e.g. 63,99,170), and there is a clear need for rigorous studies of cost benefit analysis to inform future decision making. A further area that may provide potentially useful information in relation to organising midwifery care is the measurement of workloads in relation to care quality(see 157).

6.4 Organisation of Midwifery Care

Midwives clearly recognise the importance of understanding more about the effects of the organisation of midwifery care (including the systems in operation and staffing related issues), as a recent national survey reported by Sleep et al demonstrated(120).

Numerous evaluations of different ways of providing midwifery care have been reported in the literature, usually based on scheme/s that have been provided at local level. It is difficult to draw firm generalisable conclusions from much of this work due to the variety of methodologies used and not all findings are in the same direction. The need for robust studies to inform all aspects of service planning is evident. As midwifery operates within such a complex environment there is no one method that will produce all the information required to inform service planning. For example, randomised controlled trials (RCT's) are often considered as the 'gold standard' for evaluating health care interventions. They have provided useful findings to inform midwifery care, and they will no doubt continue to make an important contribution to care(e.g. 168,170). However, RCT's will not be the method of choice for evaluating all aspects of care provision, e.g. the evaluation of organisational change, or furthering an understanding regarding how women feel about an aspect of care provision(see 63,175).

It will also be important that the sustainability of schemes is an important component of evaluations as many of the schemes reported in the literature have not survived in the long-term for a variety of organisational and resourcing issues(e.g. see 3).

The importance of matching methods to interventions and obtaining reliable results will remain a priority for midwifery research.

6.5 Effective Midwifery Care in Pregnancy

A substantial literature has been built up over the past fifteen or so years regarding research in relation to effective care in pregnancy and childbirth(see 114-115). A recent survey of midwives has also identified several topics for further investigation(120).

The data from this study indicated in particular, the need for more research regarding the role of the midwife in providing care to low risk women, especially in relation to detecting deviations from the norm as quickly as possible. Issues related to midwives' capacity in this respect were raised many times during the course of this study, particularly by doctors who often used the perceived difficulties of midwives in this area as a reason for supporting the need for medical involvement in all care. Further research based information in this area will be important in relation to the potential effects of midwife-led and midwife-only care.

SECTION 7 CONCLUSIONS

The Nature of This Study

This descriptive research study was undertaken for the primary purpose of identifying the continuing educational needs of midwives in order to develop an educational package to meet such need. A period of 2 years was allocated by the ENB for this project. During this time, the research study and the development of the educational package based on the research findings needed to be completed.

It was necessary to obtain information on the wide spectrum of activities related to midwifery practice as defined by the UKCC(9). The data obtained provide a valuable source of information regarding the provision of the maternity service from the perspective of the professional groups studied.

The findings obtained relate to midwifery practice in its broadest sense and can be used to further an understanding of many important professional and practice issues, but it has not been possible to provide an in-depth picture of any particular aspect of practice. However, the findings have been used to identify areas where further research may be useful in informing specific practice related issues.

Potential Areas for Further Research

Key examples include: the effects of the organisation of care on a multiplicity of factors, including care outcomes, relative costs and benefits of different types of care provision, and the impact on the personal and professional lives of the workforce.

In particular, further work related to the processes and outcomes of midwife-led and midwife-only care emerged as a priority.

One issue of potential importance that may impact on all these areas relates to the extent to which all midwives can provide 'holistic care' and if and when, specialist midwifery skills will be required. This issue has not been resolved within midwifery and requires priority attention.

Quality of Care Issues

Many midwives and supervisors indicated their strong commitment to providing the best possible service, in the face of enormous structural and organisational change, in often very difficult resourcing circumstances. Many examples were provided of ways in which midwives facilitated woman-centred care in a caring and sensitive manner. However, often this did not appear to occur within a formal quality monitoring framework, and there was a strong indication that the extent to which women's needs were being addressed was subject to a considerable degree of variation.

The implementation of effective quality assurance mechanisms and the underpinning of care with more structured frameworks at local level may enhance the potential for meeting the needs of all service users. The move towards more widespread use of knowledge-led practice within the maternity service appears to be of considerable importance in assuring quality, and increasing the impetus for such developments will remain a priority.

Changing Childbirth

Considerable efforts were being made to implement the Changing Childbirth indicators of success countrywide. Again, variation was apparent concerning the extent to which the principles underpinning the report were being observed in relation to implementation. There were occasions when there was no apparent link between the way the indicators were being provided and the facilitation of choice, control or continuity for service users.

In addition, there was considerable variation between professionals working in the same units regarding the extent to which they reported Changing Childbirth had been implemented. This indicated the importance of good communication (and staff involvement) at local level regarding the strategic and operational goals underpinning service developments. Important educational developments have occurred recently, such as the publication of the ENB's Midwifery Resource Pack in relation to Changing Childbirth, and widespread access to such educational sources within the profession will continue to be a priority.

Role of the Midwife

The role of the midwife in providing care to women experiencing normal pregnancy and childbirth was not very clear in many respects. There was some evidence of doctors being prone to confuse the role and responsibilities of midwives in normal and high risk cases, suggesting midwives should take full responsibility for medical and obstetric emergencies if they wanted to be practitioners in their own right.

Furthermore, on the one hand, some doctors commented that midwives refused to take responsibility for their own work making it impossible for them to be autonomous practitioners. On the other hand, there was obvious reluctance by certain doctors, particularly GP's not to duplicate work that had already been undertaken by midwives.

Good communication networks between medical staff and midwives at all levels relating to maternity service provision will be vital in facilitating an optimum understanding of roles, and the delivery of an integrated service to local populations.

Midwives generally had a good understanding of their remit but there were obvious barriers to them undertaking their full role. Again, the extent to which this occurred varied widely, as did perceptions of the midwife as an autonomous practitioner. Some midwives considered that this could only really occur if they made all decisions alone, whereas others negotiated their own practice and hence their autonomy in whatever situation they were working.

Another potentially confusing situation arose in relation to midwives' remit to provide care for women experiencing 'normal' pregnancies and childbirth, and the extent to which they should be involved in providing more 'medical/obstetric' aspects of care. This is of particular significance as pressure may be put on midwives to assist in the process of reducing junior doctors hours.

Factors Affecting Midwives Educational Needs

The organisation of the rotation system at local level emerged as a crucial factor in relation to midwives' confidence to practise. There seemed to be the potential for conflict to arise at times between the 'needs of the service' and the 'needs of individual midwives'. Managers were clearly caught in the middle of this difficult situation. However, the data suggest a strong commitment from managers and midwives alike to providing a similar kind of service, where women's needs will be met in the most appropriate context.

Although the importance of individual variation in relation to need was obvious, the data provide some important indications regarding the potential continuing educational needs of particular groups of midwives. Part-time midwives were more likely to comment on the lack of opportunities for continuing education. Those on higher grades were generally involved in providing a wider range of aspects of care, although it was not possible to determine the *actual extent* of midwives' involvement in providing various aspects of care.

This highlights the potential importance of effective supervisory arrangements being in place at local level. In this context there is a need for more reliable information to be available to inform the most appropriate way of structuring the supervision process to best address individual and organisational need.

Development of the Educational Package

The educational package that has been developed on the basis of this research study has been designed to contribute towards addressing many of the needs that have been identified throughout the study. The importance of the needs of individual midwives being identified and addressed has been a key tenet of the development of the package. The curriculum has been designed to enhance the move towards the provision of a more integrated, woman-centred service.

The development of relationships for effective practice, and the context in which care is delivered are the key themes covered by the package. The importance of midwives' capacity to negotiate their own practice from a sound knowledge base in the best interests of those using the service underpins the activities that have been developed throughout the package.

It will be important that mechanisms are in place at local level to ensure that the needs of those using the package are being addressed, and recommendations have been outlined in the Learning Handbook to facilitate this process. In order to ensure the package is meeting the aims outlined it will be important for the ENB to ensure that progress is regularly reviewed that the effectiveness of the package in relation to professional development is evaluated.

Continuing Education Needs in Specific Areas

It was not possible for all the continuing educational needs of the profession to be addressed through the package that has been developed. In particular, clinical skills, including IV cannulation, perineal suturing, ultrasonography, labour and delivery in water and CTG interpretation were identified as priority areas. Programmes of education will need to address locally identified need, and in the light of the dynamic nature of maternity service provision and the broad range of backgrounds of practising midwives regular assessment of outstanding educational need will be a continuing priority. In particular the balance between clinical and other midwifery skills needs to be carefully considered in relation to the provision of an optimum service.

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APPENDIX

DEVELOPMENT OF OPEN LEARNING PACKAGE

Project Team from School of Health, University of Greenwich

Rosemary Pope	Project Director
Lesley Graham	Project Manager - Educational Package
Margaret Cooney	Researcher
Mary Holliday	Senior Lecturer, Midwifery

Steering Committee

Lesley Page	Professor of Midwifery and Women's Health, Centre for Midwifery Practice, Queen Charlotte's Hospital (Chair).
Meryl Thomas	Director - Midwifery Education and Practice, English National Board for Nursing, Midwifery and Health Visiting
Louise Silverton	Director of Education and Practice Development, Royal College of Midwives
Maggie Redshaw	Research Fellow, Institute of Child Health, University of Bristol
Linda Brown	Course Director, Midwifery, Distance Learning Centre, University of the South bank
Sonia Crow	Assistant Director of Educational Policy, Research and Development, English National Board for Nursing, Midwifery and Health Visiting
Roslyn Corney	Professor of Psychology, School of Social Sciences, University of Greenwich
Cynthia Rickitt	Head of Midwifery Services (retired), Sunderland District Hospital
Jane Wardropper	Education Officer (retired), English National Board for Nursing, Midwifery and Health Visiting

Editorial and Consultancy Services

Jill Fardell	Consultancy Services, Jill Fardell & Associates
Lynn Earnshaw	Structural Editor, Jill Fardell & Associates

Curriculum Advisory Group

Kate Jackson	Director of Changing Childbirth Implementation Team, Department of Health
Lesley Page	Professor of Midwifery and Women's Health, Centre for Midwifery Practice, Queen Charlotte's Hospital

Karlene Davis	Deputy General Secretary, Royal College of Midwifery
Noreen Morrin	Education Officer, English National Board for Nursing, Midwifery and Health Visiting
Wendy Savage	Professor in Obstetrics and Gynaecology, Royal Hospitals NHS Trust
Norman Evans	Higher Education Consultant
A J M Cavenagh	General Practitioner (retired)
Christine Rodgers	Representative from Association for Improvements in Maternity Services
Paul Murphy	Midwife, Gravesend Hospital, Kent
Vivienne Knight	Head of Midwifery, Doncaster Royal Infirmary
Gina Criscuolo	Senior Lecturer, Midwifery, University of Greenwich
Jill Fardell	Consultancy Services (Invited member)

Project Team

Rosemary Pope	Project Director
Lesley Graham	Project Manager-Educational Package

Curriculum Development Group

Ann Phoenix	Lecturer in Psychology, Birkbeck College
Nicky Leap	Midwife, South East London Group Practice
Jan Savage	Lecturer in Anthropology, Institute of Advanced Nursing Education, Royal College of Nursing
Anne Palmer	Education Consultant/Principal Lecturer, University of Westminster
Jill Demilew	Quality Assurance Manager for Maternity Services, Tower Hamlets Health Care Trust
Tina Heptinstall	Senior Lecturer, Midwifery, University of Greenwich
Gay Lee	Midwife, St Thomas' Hospital
Jill Fardell	Consultancy Services

Project Team

Rosemary Pope	Project Director
Lesley Graham	Project Manager - Educational Package

Critical Readers

Kathryn Partington	Midwifery Officer, Department of Health
Jill Stene	Midwifery Officer, United Kingdom Central Council for Nursing, Midwifery and Health Visiting
Meryl Thomas	Director - Midwifery Education and Practice, English National Board for Nursing, Midwifery and Health Visiting
Mary Renfrew	Professor in Midwifery, Institute of Epidemiology and Health Services Research, Leeds
Mavis Kirkham	Professor in Midwifery, University of Central Lancashire
Haydn Cook	Chief Executive, Northallerton Health Services Trust
Pam Shakespeare	Senior Lecturer, School of Health and Social Welfare, Open University
Brenda Clarke	Lecturer, Faculty of Health & Social Care, University of West of England
Pauline Armstrong	Teacher Tutor, National Childbirth Trust
Norma Chadwick	Academic Developments, University of Greenwich
Janet Hadoke	Curriculum Co-ordinator for Health Studies, Telford College of Arts & Technology
Rosemary Johnson	Director of Maternity Services, Bristol
Mary Billington	Senior Lecturer, Midwifery, University of Greenwich

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Authors

Ann Phoenix	Lecturer in Psychology, Birkbeck College
Lesley Page	Professor of Midwifery and Women's Health, Centre for Midwifery Practice, Queen Charlotte's Hospital
Gay Lee	Midwife, St Thomas' Hospital

Jan Savage	Lecturer in Anthropology, Institute of Advanced Nursing Education, Royal College of Nursing
Nicky Leap	Midwife, South East London Group Practice
Wendy Savage	Professor in Obstetrics and Gynaecology, Royal Hospitals NHS Trust
Lesley Graham	Senior Lecturer, Open Learning, University of Greenwich
Gina Criscuolo	Senior Lecturer, Midwifery, University of Greenwich
Anne Palmer	Education Consultant/Principal Lecturer, University of Westminster
Mary Billington	Senior Lecturer, Midwifery, University of Greenwich

OVERVIEW OF OPEN LEARNING PACKAGE

UNIT CONTENT

This section provides a brief outline of the aims of each part of the package, and the main issues covered.

Work Planner

You will find a Work Planner at the start of each unit which acts as a link between the various parts of the package. It is there to help you to plan your learning in terms of the learning resources that you will need, and any particular arrangements which you might need to make for certain activities.

Annotated Bibliography

Brief descriptions of important texts are offered throughout the package to help you with selecting further reading. These texts have been chosen because they are easily accessible, and provide valuable additional material to support the activities in the text.

Book 1 Relationships in Practice

Unit 1 Relationships in Care

Part i: How do I relate to others?

Aim

To consider your professional relationships with women, their families and with colleagues.

Issues

- What factors contribute to your perception of positive experiences in your own practice?
- What influences the quality of an experience for all of those involved?
- How does the possession and use of knowledge influence the distribution of power in relationships between professionals and with women and their families?
- What is assertiveness, and how can it improve relationships in practice?

Part ii: Power and Communication

Aim

To explore the elements of communication and their influence on the balance of power within relationships in maternity care.

Issues

- How do knowledge and social meanings underpin communication?
- How does the language we use reflect our view of ourselves, our relationships and the context in which communication is taking place?
- How does our use of specific words and phrases affect power and communication in workplace relationships?
- What is the influence of non-verbal aspects of communication?

Unit 2 Knowledge and Power

Part i: Midwifery Knowledge

Aim

To examine different types of knowledge and the role they play in the caring relationship, focusing on the knowledge you use in practice.

Issues

- What are your own attitudes to the various types of knowledge that you use in practice?
- How can language and meaning shape a body of knowledge?
- What are the various types of knowledge used in practice, and how do we value them?
- How do we convey your values and attitudes about the different types of knowledge to the women, their families and professional colleagues?

Part ii: What others know

Aim

To examine the knowledge that other people, women and their families, other health professionals, bring to the caring relationship.

Issues

- How can we interpret the complex ways that knowledge and power are used in relationships?
- What sources of knowledge about childbearing might others, especially the women draw on?
- What different values are attached to these sources of knowledge by health professionals and by the women and their families?
- How does this affect the decisions that are made and the outcome of care provided?
- How can empathetic understanding provide insight into alternative sources of knowledge?

Unit 3 Developing Knowledge

Part i: Knowledge and practice

Aim

To focus on research-based knowledge and its role in shaping midwifery care.

Issues

- Do we take expert and professional knowledge for granted in everyday practice?
- What is your own understanding of research awareness?
- How can we integrate research knowledge into practice, and what factors prevent us from doing this?
- What assumptions do you make about a) your practice: its routines and rituals, b) the women and the tendency to stereotype and c) knowledge and the need to re-evaluate in cases of new approaches or technologies?
- How do we evaluate any new evidence which has been or could be incorporated into care?

Part ii: Skills of inquiry

Aim

To focus on the skills used to process knowledge from a range of sources.

Issues

- How can skills of inquiry and analysis be effectively used to develop professional knowledge?
- How can we use skills of questioning, analysing and reflecting to interrogate forms of knowledge (including research reports)?
- Can I implement research in my own practice?
- What are the tensions between the values underpinning traditional beliefs and practices in midwifery care and research findings, and how can I resolve them in my own practice?

Unit 4 Developing a philosophy for personal practice

Part i: Values, beliefs and childbirth

Aim

To enable you to recognise and articulate your own philosophy of midwifery.

Issues

- What events in my personal and professional life have shaped the values that underpin my daily practice?
- What are my views on some of the key concepts which lie at the heart of midwifery: birth, mothering, families and parenthood, and what factors have shaped these views?
- What is the value of having my own philosophy of midwifery?

Part ii: A personal philosophy of midwifery

Aim

To develop your beliefs in relation to the things you value about midwifery and yourself as a midwife, into a personal philosophy of midwifery.

Issues

- Why did I become a midwife?
- What is the current professional ideology and how does it fit with my professional identity and with the social view of midwifery?
- What are my views on the relationship between professional responsibility and accountability and the provision of informed choice to all women?
- How can I use my exploration of all of these issues to create my own philosophy of midwifery?

Book 2 The Context of Care

Unit 1 How are maternity services meeting the need?

Part i: The changing context of midwifery

Aim

To build a greater understanding of the wider context in which midwifery skills are practised and explore the concept of need and how it can be assessed and used as a basis of service provision.

Issues

- What factors may have contributed to change in maternity care at local and national level in recent years?
- What factors are taken into account when identifying health care needs?
- How useful are the concepts of client group and culture as indicators of needs?
- How can we resolve the differing perspectives on need and use the understanding gained in practice?

Part ii: Providing services and support for childbearing women

Aim

To examine the maternity services within which you practise and consider ways of determining whether these cater for the needs of the client.

Issues

- How is maternity service provision organised locally?
- What sources of information are available about local maternity service provision and the extent to which needs are being met?
- What factors affect any process of gathering information about needs?
- What influence do women and their families have on maternity service provision?

Unit 2 Policies, power and practice

Part i: Health policies and social change

Aim

To investigate how national policies related to maternity care are made and the influence of the prevailing social context in shaping these policies.

Issues

- How has the change in attitudes towards place of birth shaped the dominant maternity culture?
- What is the role of government reports and policy in shaping beliefs about childbirth?
- How can we analyse government policy reports in order to increase our understanding of factors that influence the recommendations made?
- How has the rise of consumerism affected government health care policy?
- Can we apply the language of consumerism to childbearing women?

Part ii: Policies, professionals and consumers

Aim

To look at factors which determine local policy making processes as a pre-requisite to providing choice for women and their families.

Issues

- How are national policies interpreted at local level?
- How do they affect practice at local level?
- How useful are satisfaction surveys and the information they provide?
- What other ways are there of obtaining information about the women's satisfaction with the service you provide?
- How are local policies and protocols made?
- Can we improve this process?

Unit 3 Midwifery practice in a woman-centred service

Part i: The medical model and midwifery practice

Aim

To examine how different philosophies of health in relation to childbearing have shaped the way midwifery care is organised.

Issues

- What is the relationship between your own personal philosophy of midwifery, the views of the women and the differing perspectives of childbearing which influence models of care?
- What are the main issues surrounding the use of technology, its role in influencing the organisation of care and how it shapes your practice?
- How have changes in the philosophical and organisational model of midwifery changed the nature of the skills required of midwives in the use of technology?
- How can technology be used in woman-centred care?

Part ii: Organising woman-centred care

Aim

To explore how a shift to a more woman-centred perspective is reflected in alternative ways of organising care, and consider how effective these can be in the context of today's health service.

Issues

- Which systems of care see pregnancy and birth as normal life events?
- What are the main factors to consider in putting the principles of woman-centred care into practice?
- What are the main organisational models of midwifery available to us within this framework?
- How is care organised in your workplace?
- Would it be possible and/or appropriate to adapt this model, or adopt another organisational model to meet the needs of your client group?

Unit 4 Developing a strategy for a woman-centred service

Part i: The process of change

Aim

To develop understanding of the nature of change and its effects.

Issues

- How does change affect your personal and professional life?
- What is the theory of change, and how are its positive and negative effects explained by theorists?
- What is your own response to the process of change?
- What are the real and hidden constraints on change?
- How is change managed within your own area of practice?

Part ii: Your strategy for change

Aim

To develop a strategy to change a particular aspect of your practice which reflects your philosophy and the context of care in your workplace.

Issues

- How do you and others in your workplace respond to change?

- How can we use examples of good practice from one care setting to improve care in another setting?
- What contributes to successful change management?
- What are the characteristics and role of an effective change agent?
- What potential do you have to adopt this role?